Safe sex and women

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Abstract

Objective—Sexual behaviour, condom use, HIV knowledge and anxiety for women were examined to understand the range of sexual behaviours, predictors of safer sex and the extent of relapse.

Design—A cross sectional sample of women STD clinic attenders completed interviews and questionnaires.

Setting—Central London STD Clinic.

Subjects—153 women drawn from consecutive attenders at a sexually transmitted disease (STD) clinic in inner London.

Results—A quarter of the sample had never responded to safe sex and a further 14% had been unable to maintain it over time. Anxiety and knowledge did not differ between safe and relapsed groups, but self efficacy and cognitive variables did. Those who maintained safe sex had significantly less sex. Ten percent of the sample had unprotected anal intercourse. Most women saw themselves in longer term relationships, yet a quarter had sex outside of the relationship and a fifth stated that their partners also did. HIV information gathering was passive and 74% felt they could not protect themselves against infection. High concern over HIV was monitored. Condom uptake was low and non-existent for anal intercourse. 25% had undergone HIV testing. These women did not differ significantly in terms of their behaviour from the untested women.

Conclusions—HIV risks for women are a source of anxiety and tailored intervention is needed to reduce risk and promote dialogue and negotiation.

Introduction

One in three of all those infected with the Human Immunodeficiency Virus (HIV) are women.¹ Despite the fact that heterosexual transmission has always posed a risk to women attentional focus is often limited or missing for this group. It is unclear why, for so long, heterosexual spread has been ignored or overlooked. The lack of acknowledgement of female HIV infection has serious ramifications. For women with AIDS diagnosis is often made late or not recognised.² As treatment for opportunistic infections improves, this is a serious impediment for women.

As paediatric infection is becoming more prevalent, women are receiving more attention. Yet this is not purely in their own right,

but more so as the vectors of infection to ("innocent") babies and thus concentrating on issues of pregnancy.

The fact that globally there are more men with HIV than women implies that currently women are at great risk of infection. Prevention often entails adjustment of specific sexual behaviours.³ However, few people examine the extent to which such behaviour change is feasible for women and which factors are used by women to do this.⁴ Furthermore, when behaviour change occurs, it is unclear to what extent this is maintained over time or whether such change is transitory lasting only for the period of media emphasis.⁵ Worth notes⁶ that the most common response to risk of infection for women is not the uptake of condoms in her sexual encounters but restriction to one partner, altering partners or having less sex.⁷ Yet such behaviour may still expose women to risk if their sexual partners share needles or have multiple partners themselves⁶ or they are in the sex industry.⁸⁻¹³ Richardson⁴ points out the contradictions experienced by women who carry condoms. Such women may be perceived as "easy". Women who suggest alternatives to penetrative sex may endanger relationships and the self esteem of her partner.¹⁴

Many educational and media projects fail to acknowledge that sexual decision making for women is not straightforward. Often it is not simply knowledge that engenders behaviour change, but more complex notions concerned with socio-economic standing, power, self-esteem, dependency, culture and the competing challenges of a desire to conceive and the desire to protect themselves.¹⁵

As male sexually transmitted disease (STD) clinic attenders are thought to be of particular high risk of HIV transmission¹⁶ the aim of this study was to catalogue the particular sexual behaviours of women attenders at STD clinics in the light of HIV and to examine facilitators and impediments to the adoption and maintenance of safe sex. It was hypothesised that many women would still indulge in unsafe sex and have limitations on their ability to protect themselves.

Methods

Consecutive attenders at a STD clinic in central London were asked to complete an anonymous and confidential self-completion questionnaire on sexual behaviour. Completed data was gathered from 67.5% of all attenders. Non-completion was associated with non-fluent English language, speed of processing

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through the clinic, incomplete questionnaires or a desire not to participate. The sample consisted of 153 women with a mean age of 26.23 years (SD 7.01) and income spread of £10–15 000 per annum. The average age of leaving formal education was 18.7 years (SD 3.2) and the mean number of sexually active years was 9.4 (SD 7.4); 24.18% of the sample had an HIV test and 2.6% of the sample were HIV positive, 83% of the sample were in a primary sexual relationship and the average length of the relationships were almost three and a half years (181 weeks). Of those in primary relationships, 19.6% had outside sexual contact.

The study questionnaire assessed a broad range of variables related to responses to the threat of HIV infection/AIDS. Subjects described in detail their current and past sexual behaviour, together with current anxiety levels (Spielberger Current State), condom appraisal, health education appraisal, and a series of inventories evaluating endorsement and cost benefit appraisal of three safer sex measures (condom use, reduction of partners and non-penetrative sex). Responses were on Lickert type scales of endorsement and agreement. Health education exposure was monitored by using eight specimens of UK health education material drawn randomly from material appearing over the previous 5 years. Subjects rated recognition, endorsement and agreement.

Results

1. Descriptive data

Number of Partners: The women reported a mean of 1.1 partners with 11.1% reporting none, 76.5% reporting one and 12.5% between two and 15 partners over the past month. Of these 20.4% did not have regular partners.

Anal Intercourse: The majority of women did not report anal intercourse over the previous month (89.3%), but the remaining 10% reported anal intercourse with a frequency of 1–30 occasions over the previous month. All anal intercourse was unprotected in this sample.

Unprotected sex: Over the previous month 66% of the sample reported unprotected sex; 83% with main partners and 23.8% outside their relationship. Furthermore 19.5% report that their partners have sex outside their relationship and a further 25.2% not knowing about partner fidelity.

Alcohol and drugs: 59.5% of this sample were not drunk prior to sex. The remainder had imbibed some alcohol, with 17% saying this to be of notable quantity. Fewer used drugs with 70.5% stating they had not used drugs. The remainder had done so to varying degrees.

HIV concerns: The women were worried about HIV with 28.5% scoring at the maximum point of the scale and 71.5% over half way. Only 9.9% were not worried. Such concerns did not lead to automatic belief in control and empowerment. Of the sample 74.3% felt they could not do anything to protect themselves against infection. HIV testing, an anxiety laden activity, had been undertaken by 25% of the sample with some having multiple tests (14.9%:

had one test, 6.1% had two tests and 4.1% had between three and ten tests). All women in the sample were heterosexual. Of the group 4 (2.7%) were HIV +ve, 33.6% were HIV –ve and the remainder (66.4%) did not know their HIV status.

HIV/AIDS information: Information gathering was, on the whole, passive rather than active as 91.4% of the group had never telephoned for AIDS advice, with a small group (8.6%) having done so once or twice. 93.5% had never written off for written material on HIV. 86.9% had never bought written material and 90.6% had never attended group meetings. 92% had not discussed the issue with a counsellor and 86.9% had never discussed the issue with a health adviser, despite the fact that they were in an STD clinic and a high proportion (61.8%) had attended in the past. Yet 22.3% had raised the issues of HIV with their general practitioner. Passive information exposure was greater, with 86.3% reporting exposure to television programmes, and 33.8% regularly watched such items.

Condoms: Previous condom experience (lifetime) was high with 95.6% of the sample stating that they had used a condom at some point in their life. Current use was much lower with 40.4% reporting that they never used condoms now and 23.9% did not use condoms with casual partners. Dissatisfaction was notable with 50.4% recalling condom failure and 45.2% reporting other difficulties.

Last sexual encounter: Most women reported vaginal sex (66.4%), with only 1.5% reporting anal intercourse. Sex occurred at their home on 62.2% of the occasions, at their partners home on 28.1% and at another venue on 9.6% occasions. The majority, 85.9% had had sex with this partner previously. For 62.7% no mention was made of condoms. When mentioned this was by the women most often (17%), by the man (6.7%) or both (13.4%). There were condoms to hand in 48.5% of cases which belonged to the woman in 53.4% of those instances. Yet it was not used on 55% of the instances even when it was to hand. Alcohol intake at the time of this encounter was none for 67.2% and above 4 on a 7 point scale for 13.7% of women. Drugs had not been taken by 88.5%. Fatigue was also mentioned by 43.4%. A high desire for unprotected sex at the time was stated by 31.7%.

Sex negotiation: 11.8% did not talk at all about the sexual episode, either before or after, but 56.7% spoke quite often. Normative influences may be high, as 32.5% of friends did not encourage safe sex adoption. 12.6% stated that they made their risk judgement of their partner on appearances alone.

2. Safe Sex

Eighty seven (61.7%) women stated they had taken up safe sex and were maintaining it. A further 20 (14.2%) women reported that they had taken up safe sex but had relapsed to risky behaviour. Thirty four women (24.1%) had not responded at all to safe sex. Comparisons were carried out between these three groups (table).

Table Comparisons between safer, relapsed and non-reactive women

Variable	Group mean scores			F/Sig
	Safe	Relapsed	Non reactors	
% of sample	61.7%	14.2%	24.2%	
Age completed education	19.4	17.4	17.5	6.0†
Anxiety Score (Spielberger)	40.3	41.1	42.3	0.3 ns
Knowledge of AIDS score total	14.8	14.6	14.6	0.04 ns
Years sexually active	9.4	11.7	8.9	0.9 ns
<i>Sexual behaviour in previous month</i>				
Mean no of sexual partners	1.2	1.2	0.9	0.5 ns
Mean no regular sex partners	0.8	0.9	0.8	0.6 ns
Frequency of anal intercourse	0.6	0.1	0.4	0.5 ns
Frequency of vaginal sex	7.0	13.7	13.2	7†
Frequency vaginal sex with condom	4.3	10.9	12.9	11†
Frequency non-penetrative sex	2.1	1.2	3.8	1.9 ns
<i>Psychological measures</i>				
Total scores for endorsement of concepts relating to:				
Self efficacy to utilise safe sex	62.6	57.7	54.0	10.5†
Cost benefit of safe sex	57.1	54.1	48.6	7.8†
Effectiveness of safe sex measures	20	18.2	19.2	2.4†
Social desirability of safe sex	27.8	26.3	24.5	2.3†
Rating of perceived risk personal risk (7 point scale)	2.5	3.1	2.7	2.6†
Social Desirability Scale (General behaviour)	2.6	1.7	2.7	3.4*
<i>Health Education</i>				
(total ratings for 8 items on 7 point rating scales)				
Recognition of material	23	26	17.3	3.9*
Agreement with message	38.5	39.6	31.9	2.8†
Influenced by message	30.3	33.4	22.1	4.1*

†p < 0.10, *p < 0.05, †p < 0.01.

Those who maintained safe sex had significantly less sex, and less unprotected sex. They had significantly higher scores of self efficacy and ratings of cost/benefit of safe sex measures. They also had significantly more years of education. The relapsed group were more likely to recognise, agree and be influenced by health education material.

3. HIV testing

25% (n = 37) of the sample had been tested for HIV. Comparisons were carried out between those who were tested and those who were untested. The tested had a higher frequency of vaginal intercourse but this did not reach statistical significance ($t = 1.2$, $p = 0.09$). They did not differ systematically on other variables.

Discussion

These data are limited in that they reflect on STD attenders and can thus not be generalised to the female population as a whole. Furthermore, there were no data on those who did not participate in the study and thus the totality of experience is not fully covered. Yet this study may provide some pointers for future input given the paucity of data on female experience.

The data that do emerge suggest that safe sex messages are getting through to just over 60% of these women STD attenders. However, a consistent tenth are relapsing and a quarter of the sample, despite higher risk exposure, are not responding to safe sex messages at all. The level of long term maintainance is unknown and it is possible that with time a larger proportion of the group will relapse. Indeed, even within the group who perceive themselves as "practising safe sex", risky behaviours were noted. Without dialogue and counselling such

women may be unaware of their risks. Such awareness must be a necessary, though not sufficient, component in any programme of behaviour change.

Most women report few partners with many women reporting regular partners. Hence such women will not see messages about promiscuity as pertinent to them. Yet 23.8% of women reported sex outside of their primary relationship and 19.5% reported that their partners had sex outside as well. This would indirectly expose a large number of subjects to multiple contacts and risk levels may be higher than they appear.

Safer sex behaviours were difficult for many women. All occasions of anal intercourse were unprotected for this sample. This is a particularly effective route for HIV transmission which seems to be overlooked in the heterosexual literature. Women rarely report condom use if they are having sex with a known (or regular) partner. It may be easier for women to introduce condoms with an unknown partner than to take them on board in an established relationship.⁶ Safe measures were more likely to be a reduction in frequency of sex than condom uptake. Given that HIV can be transmitted at a single exposure, such efforts may only afford limited protection.

Alcohol triggers for unsafe sex have been examined in the literature.¹⁷ Although most women had not used alcohol prior to sex, 17% of the sample had imbibed a notable quantity. Sexual decision making may be affected in the presence of alcohol and future studies should examine the role of alcohol when both partners are affected. At their last sexual encounter 62.7% made no mention of condoms. Condoms were to hand in 48.5% of cases (often belonging to the woman) yet it was only used in half the instances when it was available.

Women in this group were concerned about HIV. A quarter had received HIV testing. It is important that negative HIV tests are not seen as permission to continue risky behaviour or to confer some form of "immunity" on women.¹⁴ In depth discussion on HIV was lacking for this group, despite often multiple attendance at STD clinics. The anonymity of STD clinics may mitigate against dialogue as over a fifth of the sample had raised the issue with their general practitioner and it may be that this is an avenue of first choice for information. This has funding and training implications for general practitioners who may be ideally placed to reach out to women with HIV counselling.

Sex is often not discussed or negotiated by women.⁶ This behaviour may be endorsed by normative influences as this sample reported that for 32.5% friends did not encourage the adoption of safe sex. Although just under two thirds of the group had responded to safe sex 14.2% had relapsed to risky behaviour. A quarter of the sample had not responded to safe sex at all. Those who maintained safe sex had less sex and recorded significantly higher levels of self efficacy and benefits for safe sex measures. They had significantly more years of education. Neither anxiety nor knowledge scores were factors differentiating the maintainers with the

relapsers or those who ignored safe sex altogether. This underlies the contention that safe sex is not a simple step following on from information. Health education campaigns were highly recognised and endorsed by relapsers who were significantly more influenced by them. Yet this effect was transient as these groups relapsed over time. These data suggest that women are exposed to many risks via their sexual behaviour. Condom use is low and non-existent with anal intercourse. Even when condoms were to hand, they were not used in over half of the instances. Negotiation skills are low and sex often occurred in the absence of dialogue. Women may find such negotiation particularly difficult in the presence of longer term relationships. Sex outside of relationships is common and is mostly unprotected. Risks are increased by the existence of reported sex by partners outside of the relationship.

This study shows that high profile health education material is noticed by the female population. Those who take particular note respond in the short term, but relapse in the longer term. Information flow via such campaigns is a passive way of informing women. Dialogue is missing if this medium is used. Few women have discussions with health care workers at the STD clinics despite the fact that such workers probably have good levels of training and expertise.

Women who had undergone HIV testing did not differ significantly from those not tested. It does not appear, from these data, that women are using HIV negative test as a "reprieve" or a trigger for sexual behaviour change as in the other groups.⁵

It is trite to think that safe sex adoption is simply a question of will for many women. Sex is often a much more complex behaviour,

affected by the extent to which the women are empowered to negotiate their sex and the costs to them of withholding such sex. The fact that 10% of the sample were having unprotected anal intercourse and 74% felt they could not protect against infection highlights the urgent needs for women.

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