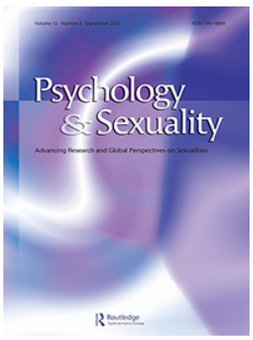

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‘I just tell myself it’s okay’: U.S. women’s narratives about sexual safety and how they assess risk for sexually-transmitted infections

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'I just tell myself it's okay': U.S. women's narratives about sexual safety and how they assess risk for sexually-transmitted infections

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ABSTRACT

While some researchers have studied the spread of sexually-transmitted infections and diseases (STIs and STDs), little attention has been paid to the subjective narratives of how women assess sexual safety and the possibility of contracting STIs when having sex with partners. This study analysed semi-structured interviews with twenty women from a diverse 2014 community sample collected in a large Southwestern U.S. city in order to examine how women assess safety and danger in partners with regard to their sexual health. I identified five themes in how women described assessing their risk for contracting an STI: 1) Avoidance and refusal to ask; 2) Intuiting safety or 'just feeling' they are STI-free; 3) Verbally asking and trusting their responses; 4) Checking for physical signs of STIs; 5) Asking that a partner get tested. Tensions about sexual health knowledge, entitlement to ask for proof of a partner's STI status, and the gendered power dimensions of sexual health and sexual risk-taking are discussed. Ultimately, women's overwhelming lack of effective measures to ensure their own sexual health and safety are put into conversation with discourses of sexual (dis)empowerment.

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Risk perception; sexual health; sexual safety; sexually-transmitted infections; sexual knowledge; women's sexuality

Introduction

Links between risk and sexuality are omnipresent in U.S. popular culture and sexual health discourses. Warnings of sexually-transmitted infections (STIs), unwanted pregnancies, and sexual risks permeate the language used around sexual health and sex education, particularly for younger women and teenage girls (Bay-Cheng, 2003; Cameron-Lewis & Allen, 2013; Irvine, 2004). That said, the U.S. has some of the highest rates of sexually-transmitted infections and teen pregnancy of any developed country in the world (Darroch et al., 2001; Weaver et al., 2005), with 37.7% of female adolescents ages 14–19 reporting at least one STI (Forhan et al., 2009). Further, certain groups of women are especially prone to sexual risk-taking, including those with histories of sexual trauma (Hillis et al., 2001), those with more impulsivity and sensation seeking personalities (Hoyle et al., 2000), and those with more trust in their partners (Skidmore & Hayter, 2000). This link between the commonplace narratives of sexual risk-taking and the high rates of STI transmission suggests an important gap in the existing literature about how women make sense of, or evaluate, their potential sexual safety or risks.

In particular, researchers have shown that acquisition of new sexual partners is particularly risky (Niccolai et al., 2004; Ott et al., 2011). How women negotiate the use of condoms has important implications for their sexual health and, in many cases, for the relationship itself (Cleary et al., 2002; East et al., 2011). Women often have faulty beliefs about their own risks and the risks of their peers

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(Downing-Matibag & Geisinger, 2009). That said, previous studies have typically addressed the behavioural components of sexual risk-taking, including who uses protection, what type of protection they use, and which groups have higher risks than other groups. Narratives about sexual risk-taking and how women understand and rationalise risks are studied far less often. In an effort to better understand how women determine their sexual risks and what measures they take to ensure that they avoid STIs from partners, this study examined qualitative narratives from semi-structured interviews with twenty U.S. women with diverse backgrounds (race, age, current relationship status, parental status, class backgrounds, and sexual identities) in order to examine women's feelings about how they assess safety and danger in new partners. Specifically, this study examines how women determine if a new partner might have (or potentially transmit to them) an STI, and what these narratives reveal about gender, power, and sexual health. How women talk about STIs – or whether they feel they can talk at all about them with partners – is a major focus of this study.

Literature review

Sex education and sexual risk

Sex education curricula in the U.S. overwhelmingly depict young people, particularly girls, as at risk for contracting sexually-transmitted infections (Bay-Cheng, 2003; Irvine, 2004; Levine, 2002). The descriptions of the many possibilities of STIs form a central part of many sex education curricula, often complete with vivid photos of infected genitalia (Fields, 2008; Levine, 2002). This, coupled with warnings about unwanted pregnancy and sexual violence, work to create an early picture of sexuality as fraught with risk and prone to various dangers and disasters. (Note that not all countries depict sex in this way. Many sex education curricula in Europe, for example, emphasise the negotiation of pleasure and power, sexual communication, and consent and have called out US curricula as flawed and limited for focusing so heavily on STIs. See Giami et al., 2006; Parker et al., 2009).

This framing of sexuality – abstinence as best, risk as omnipresent, sexual subjectivities as minimal – often leaves out discourses of pleasure, orgasm, sexual assertiveness, and body image, creating what Fine (1988) famously called the 'missing discourse of desire.' Reflecting nearly 20 years later, Fine and McClelland (2006) wrote:

> The capacity of young women to be sexually educated—to engage, negotiate, or resist—was hobbled by schools' refusal to deliver comprehensive sexuality education. The power of this argument lay in naming the relationship between the absence of sexuality education on desire and the presence of sexual risk. (p. 297)

In addition to excluding these other facets of sexuality, the concern for sexual risk-taking promotes the core belief that scaring teenagers about their sexual health will promote sexual-health-seeking behaviours (Froyum, 2010; Irvine, 2004; Levine, 2002). And yet, studies show that fear-based sex education tactics often fail to translate into healthy behaviours like using condoms and birth control and understanding the nuances of sexual consent (Irvine, 2004; Santelli et al., 2006).

Further, the increase in abstinence-only sex education curricula means that many teenagers are receiving messages about sexual risk without getting any training or teachings about how to *prevent* such infections (Hindman & Yan, 2015; Kirby, 2008; Stranger-Hall & Hall, 2011). Fewer and fewer programs are teaching students how to put on condoms (or other barrier methods of birth control), how to get tested for STIs, and how to minimise their risks for STI transmission and infection (Hindman & Yan, 2015; Irvine, 2004). And, of course, many schools without mandatory sex education programs are foregoing all sex education entirely; Arizona, for example, has no state-mandated requirement for sex education (Altavena, 2019). A full 21% of Arizona students are never taught about HIV/AIDS or STIs at all (NARAL, 2017).

Popular depictions of sexually-transmitted infections

In addition to learning about sexual health from more traditional sex education programs, women also learn about sexual health from popular culture, including movies, television, and online sources. Popular culture depictions of STIs are also mired in contradiction, in that women's magazines like *Glamour* and *Cosmopolitan* portray STIs and STDs as ubiquitous, disgusting, dangerous, and menacing, while also promoting casual sex as pleasurable and desirable (Clarke, 2010). Another study of newspaper coverage of STIs found that very few articles are printed about STI infections, and even fewer give any details about prevention and transmission; the study found that only 19% of the newspapers surveyed had articles that 'mentioned the causes, consequences, prevention, signs, or symptoms, screening, transmission, treatment, trends or rates of STDs' (Davidson & Wallack, 2004, p. 115). Those magazines that did advertise for STD prevention occurred primarily in magazines targeting African-Americans (with half of the ads featuring only African-American models) (Mastin et al., 2007).

Looking more closely at media depictions of gender and STD prevention, one study that looked at television, magazines, music, and movies popular with adolescents found that less than 0.5% included information about or depictions of sexually healthy behaviour. Instead, most of these media outlets depicted sexual health as inaccurate or ambiguous while reinforcing traditional gender roles that portrayed women as responsible for preventing pregnancy and contraception as embarrassing or humiliating (Hust et al., 2008). Girls have become connected to 'sexually transmitted infection' for the promotion of Gardasil, largely ignoring that boys also carry HPV, which feminises STDs in the popular media (Mara & Scott, 2010). Magazine headlines in women's magazines frame STIs as a hazard for dating: 'I have an STD. Will my new guy reject me?' (http://www.cosmopolitan.com/sex-love/advice/a6388/ask-logan-std-herpes/). Additionally, compared to other health issues, STIs are depicted with high amounts of stigma in the mainstream media (Smith, 2007), which may further impact how people think about sexual risk and safety.

Who can insist on sexual safety measures?

Perhaps because of the inconsistent stream of information women receive from both sex education programs and from popular media, women often struggle to discuss their sexual health with partners (Cleary et al., 2002). A number of barriers exist to practicing safer sex, including sexual double standards, access to contraception, the ability to ask for or about STI testing, intimate partner violence, family systems issues, discrimination based on sexual identity, and length of the relationship with a partner. Sexual double standards – where women are expected to be sexually available but are still saddled with taking responsibility for sexual acts – impacts women's sexuality by reinforcing gender-specific standards of sexual permissiveness (Crawford & Popp, 2003; Eaton & Rose, 2011; Jonason & Fisher, 2009; Muehlenhard et al., 2003). Sexual double standards discourage women from negotiating safer sex (particularly during the first encounter), leading women to choose between the risks associated with unprotected sex and the potential negative judgements of their partners (Higgins & Browne, 2008). Women experience difficulty when negotiating safe and pleasurable sex behaviour with partners (Chmielewski et al., 2020; Impett & Peplau, 2003), with nearly 20% of women ages 14–24 reporting that they never believed they had a right to make decisions about their contraception (Rickert et al., 2002).

Research has shown that there are important differences between women who feel they can ask for STI testing or for a partner to use protection compared to those who cannot. Silencing, women's fear of violence, and internalised oppression all impact who feels they can reduce their STI risk (Amaro & Raj, 2000), as can social status and relationship characteristics (Kaestle, 2009). One study found that those women who engaged in unprotected vaginal and anal intercourse had lower self-efficacy to discuss safe sex with a partner, lower self-efficacy to refuse unsafe sex, and lower overall self-efficacy (Boone et al., 2015). Women with a higher desire for pregnancy reported a higher

number of STIs than those who did not want to get pregnant (Finger et al., 2012), while those with partners older than them reported more episodes of unprotected sex (Senn & Carey, 2011).

Further, partner violence was associated with STIs among adolescent girls, as girls who experienced intimate partner violence reported higher sexual risk behaviours, more unprotected anal sex, more deception from their partners, more fear of requesting condom use, and more coerced condom non-use (Silverman et al., 2011). More nuanced studies of condom use have found that many avoid condoms because they fear it threatens close relationships (Afifi, 1999).Women also feared asking partners to use condoms based on their relative lack of power in their relationships (Woolf & Maisto, 2008), a subject that has led to compelling methodological advances in studying and intervening in HIV risk (Rosen et al., 2018).

Along these lines, family systems can also help to predict sexual safety issues, as those who experienced childhood maltreatment by parents or adult caregivers (e.g. sexual abuse, physical abuse, and neglect) more often contracted STIs than those without such a history (Haydon et al., 2011). Further, those with stronger intergenerational family connectedness – that is, knowing stories about grandparents or great-grandparents – reported lower sexual risk-taking behaviours (Landau et al., 2000). A study of African-American teen girls found that living with mothers in a supportive family predicted more communication with sexual partners about risk as well as less unprotected sex (Crosby et al., 2001).

Sexual identity also impacted women's STI risk in some notable ways. Women who had sex with men engaged in a variety of behaviours to keep them safe, including controlling their own sexual desire, developing strict contraceptive regimens, and emphasising relational contexts of 'waiting' for sex" and developing 'care' decision-making, suggesting that heterosexual sex requires constant emotional and psychological labour from young women (Dutcher & McClelland, 2019). Further, another study found that sex between women was discursively understood as 'safe' and that women who had sex with women saw themselves as having low risk for STIs (Souto Pereira et al., 2019) and as having low risk for transmission of HPV (Agénor et al., 2019. Lesbians had higher rates of sex with bisexual men combined with higher rates of condom use compared with bisexual or heterosexual women (Koh et al., 2005). Women who identified as mostly gay or gay had lower STI risk than heterosexual-identified women, but women with two or more female partners had higher STI risk than women with only male partners (Lindley et al., 2013). Another study also found similar results, in that sexual-minority women engaged in higher risk sexual behaviours and were more likely to acquire an STI or HIV than heterosexual women, perhaps due to elevated stigma (Mojola & Everett, 2012); this suggests that there is an urgent need for better sex education and gynaecological screenings for sexual minority women (Lindley et al., 2013). Further, LGBT individuals in abusive relationships reported high instances of sexual coercion (41%), fear of asking for condom use (28%) and direct violence as a result of asking to use sexual protection (Heintz & Melendez, 2006).

The gap between recognising STIs as a problem and taking initiative to get tested for STIs has also been noted in the literature. One qualitative study found that knowledge about STIs did not relate to the action needed for preventing STIs, as people were more afraid of being rejected by a partner than they were of contracting an STI (Pliskin, 1997). A study of African-Americans found that 76% perceived STIs as a problem in their community, 91% felt that people needed education to learn how to avoid STIs, but only 49.5% agreed that they should get tested for STIs because they may be at risk (Uhrig et al., 2014). Building on this, one study found that people had significant blind spots about behaviours that their current partner engaged in, including having another sexual partner, engaging in IV drug use, having an STI diagnosis, and being HIV-positive; further, Black and Latina women were especially at risk for not knowing about their partners' risk factors (Witte et al., 2010).

Ultimately, relationship type also impacts the ability to negotiate safe sex practices. While quantitative studies have shown that women initiating sex for the first time with a new partner less often use safe sex measures (Niccolai et al., 2004; Ott et al., 2011), qualitative studies also validate that women struggle to request condom use or safe sex techniques with partners, particularly new partners or those with low relationship quality (Cleary et al., 2002; East et al., 2011; Watson & Bell,

2005). Some women also associate lack of condom use with love, and see protected sex as competing with discourses of love (Rosenthal et al., 1998). Further, given that feminist rhetoric emphasises contradictions between women's sexual empowerment and gender imbalances, women may face competing messages about consent and sexual safety (Burkett & Hamilton, 2012).

Research questions

Given the complicated ways that women assess, or avoid assessing, sexual risk, this study began with several research questions to guide its analysis: First, given that Arizona has no mandated sex education programs in schools, and because women often learn about sexual health from media sources and popular culture, what do women say about sexual safety and risk prevention, and how does this connect to their sexual health knowledge? Second, how does women's assessment of risk connect to beliefs about what is safe, entitlement to ask about potential risks, or to their feelings about sexual safety? And, finally, how do women's ideas about STIs connect to broader stories around gender, risk, power, and sexual scripts?

Method

This study utilised qualitative data from a sample of 20 adult women (mean age = 35.35, SD = 12.01) recruited in 2014 in a large metropolitan Southwestern U.S. city. Participants were recruited through local entertainment and arts listings distributed free to the community as well as the volunteers section of the local online section of Craigslist (for the benefits of using Craigslist to recruit participants see Worthen, 2014). Both outlets reached wide audiences and were freely available to community residents. The advertisements asked for women ages 18–59 to participate in an interview study about their sexual behaviours, practices, and attitudes. Participants were selected only for their gender, racial/ethnic background, sexual identity, and age; no other pre-screening questions were asked. A purposive sample was selected to provide greater demographic diversity in the sample: sexual minority women and racial/ethnic minority women were intentionally oversampled and a diverse range of ages was represented (35% or 7 ages 18–31; 40% or 8 ages 32–45; and 25% or 5 ages 46–59). The sample included 60% (12) white women and 40% (8) women of colour, including two African-American women, four Mexican-American women, and two Asian-American women. For self-reported sexual identity, the sample included 60% (12) heterosexual women, 20% (4) bisexual women, and 20% (4) lesbian women. All participants consented to have their interviews audiotaped and fully transcribed and all received USD 20.00 USD compensation. Identifying data was removed and each participant received a pseudonym to ensure anonymity. Participants directly reported a range of socioeconomic and educational backgrounds, employment histories, and parental and relationship statuses.

Participants were interviewed using a semi-structured interview protocol that lasted for approximately 1.5 to 2 hours, where they responded to 32 questions about their sexual histories, sexual practices, and feelings and attitudes about their sexuality and their body. This study and the specific interview protocol were both approved by the Institutional Review Board. All participants were interviewed by the author in a room that ensured privacy and confidentiality of responses. As a middle-aged white fat female professor, my identities likely impacted these conversations in significant ways (e.g. participants believing that professors are 'rich,' commenting on how they imagined I must be married with children, identifying or distancing from my weight, etc.).

This study is part of a larger study about sexuality and thus the research questions for this study emerged after the data was collected. Questions related to this study emphasised women's narratives about birth control, STIs, and how they determine whether a potential new partner has an STI. Women were asked two prior questions about sexual risk and safety: 'Some women report consistent use of birth control and contraception while others are more inconsistent. How do you negotiate the use of birth control and what factors into your decisions to engage in sex with or without birth

control?' and 'Have you ever contracted a sexually-transmitted disease or infection?' This was followed by the primary question of interest for this study: 'How do you determine the safety with future or current partners in terms of sexually-transmitted infections?' These questions were scripted, but served to open up other conversations and dialogue about related topics, as follow-up questions, clarifications, and probes were free-flowing and conversational.

Responses were analysed qualitatively using a phenomenologically oriented form of thematic analysis that draws from feminist theory and gender theory (Braun & Clarke, 2006). This type of analysis allowed for groupings of responses based on women's responses to the questions about sexual health and STIs (e.g. avoidance, intuiting that a partner is STI-free). To conduct the analysis, I familiarised myself with the data by reading all of the transcripts thoroughly, and I then identified patterns for common interpretations posed by participants. In doing a feminist phenomenological analysis, I looked for broader patterns about how participants constructed themselves in relation to risk and how these narratives linked with social frameworks like 'intuiting' STIs versus asking directly about STI status. In doing so, I reviewed lines, sentences, and paragraphs of the transcripts, looking for patterns in their ways of describing attitudes about sexually-transmitted infections (Braun & Clarke, 2006). I selected and generated themes through the process of identifying logical links and overlaps between participants. After creating these themes, I compared them to previous themes expressed by other participants in order to identify similarities, differences, and general patterns. I then utilised a small team of readers (one graduate student and one undergraduate student) who read the transcripts separately. In the course of meeting together twice, we refined and reworked the themes until we arrived at a mutually agreed upon list of five themes that reflected women's narratives about sexually-transmitted infections and sexual safety. There was one instance where we disagreed so this discrepancy was resolved through discussion between the coders. Once these themes were generated, we reread the transcripts to see if each person coded the same passages in the same way (drawing from the recommendations of Campbell et al., 2013).

Results

All participants had something to say about how they determine sexual safety and STI risk in a current or potential sexual partner, though they discussed their feelings about this in notably different ways. (Notably, seven women in the sample had had a sexually-transmitted infection, two women were 'not sure' about whether they had had an STI, and 11 women said that they had never had an infection.) This study identified five themes associated with how women determine the safety of a future or current sexual partner in terms of STIs: 1) Avoidance and refusal to ask; 2) Intuiting safety or 'just feeling' they are STI-free; 3) Verbally asking and trusting their responses; 4) Checking for physical signs of STIs; 5) Asking that a partner get tested. As evident in the descriptions below, some participants' responses overlapped between themes in that one participant's responses fit into multiple themes.

Theme 1: avoidance and refusal to ask

As one of the most common themes, seven women described that they avoided asking partners about STIs and refused to ask them about their sexual health status. Some women expressed that they felt guilty or bad about not being more direct about talking about risk with partners, while others did not think conversations about STIs was a priority. Antonia (25/Mexican-American/Lesbian) admitted that she rarely has even considered it but recognised that that was problematic: 'I've never been good about that [thinking about STDs). I just don't ask about it. I probably should. I've only jokingly brought it up and brushed off the seriousness of it, like "Yeah, sure."' Martha (52/White/Heterosexual) said that she had rarely thought about STI risk at all, even though she has had several STIs: 'I don't think I'm gonna have another problem [STI]. When my husband and I got back together, I just assumed that he'd be okay. It didn't cross my mind until long after.'

At times, the avoidance of the discussion related to the belief that a partner would tell them if necessary. Corinne (21/White/Bisexual) said that she always trusted partners to bring it up if they wanted to: 'If I'm in a relationship I feel like they would tell me if they did. I just trust that they'd tell me.' Daphne (33/White/Heterosexual) has also felt that she could not ask about STIs and has inconsistently asked for condom use: 'If a man doesn't automatically initiate condom use, I wouldn't bring it up and I would agonise about it the whole time. As I've gotten older there have been partners where we've decided not to use condoms. It's always confused me, like why am I willing to put myself at risk? Why am I not demanding more? Why don't I ask about whether they have something? I don't have a lot of good answers to that. Thankfully I have not been compromised.' In this latter story, the conflict about avoiding the conversation about risk and safety is more evident, though this only appeared infrequently in women's narratives.

Theme 2: intuiting safety or 'just feeling' they are STI-free

Four women mentioned that they intuited their sexual safety or relied on them 'just feeling' that their partners do not have any STIs. For example, Gail (46/White/Bisexual) relied on her instincts to tell her if a partner would put her at risk: 'Being that I engage in a lot of casual contacts, now I most heavily rely on my gut instinct. I look for someone who I just feel is disease and drug-free.' Similarly, Gretchen (52/White/Heterosexual) said that she just felt out whether they were 'clean' and mostly did not care about STIs: 'It seems like such a theoretical question! It's hard to answer. I just think to myself, "Does this person look clean?" I think about it secretly and look for a red flag. Part of why I don't care as much is that everyone is getting HPV so you don't have to worry about it. Pretty soon everybody's gonna have herpes. Everything can be treated so I don't care.'

Similarly, two women mentioned that they just trust their partners and that they can intuit whether there is risk involved. Lila (36/White/Heterosexual) said that she used 'trust' for STI protection and also admitted that she did not tell partners about having herpes: 'I use trust to tell. I can tell if they're the player type so I just judge by their type. I can tell. I've been very lucky. I don't like to use condoms but I just hope and trust that it will be okay. I have herpes and sometimes I feel guilty when I don't tell somebody. I only have sex when I don't have symptoms but I don't tell them.' Naomi (18/White/Bisexual) also relied upon trust and intuition to tell if a partner had an STI: 'It has to be mutual trust. There is no way of knowing. You know, maybe this person doesn't know they have a sexual disease. It's admirable to take them to a clinic and both get tested or something but in the real world that doesn't happen. So I just really have to use my judgement and intuition and just sense it. I just tell myself it's okay.'

Theme 3: verbally asking and trusting their responses

As another common theme, women asked their partners and then trusted their responses, as six women said that they did this in order to determine their sexual safety. Sofia (42/Mexican-American/Heterosexual) said that she asks many questions about a partner's life and also would trust the authorities to notify her if he had HIV/AIDS: 'You need to be careful on who you're gonna have sex with. I need to know literally everything about your life, completely. I won't say it but I will try to investigate it, you know? I'll ask lots of questions about lots of things. Don't the authorities tell you if someone has AIDS though? Or major diseases? I'm sure in that case the police would tell me.' Zari (43/African-American/Heterosexual) said that she talks with partners about their histories but never gets tested: 'I get to know their personality and if they're the type of person I can trust. I communicate with them about health problems and stuff like that. I guess somebody could fool you so it's not fool proof to ask but that's what I do. I've never asked a guy to get tested. Mostly it's just trust.'

Other women expressed less anxiety about the conversation process and just asked about STI status. Iris (22/Mexican-American/Lesbian) said that she just inquired and left it at that: 'I just ask if they have one. I think I have good judgment in people. I would be able to tell if they're not telling the truth and I can take their word for it and tell if they're lying or not. They're going to generally be

honest before giving you something. I just ask my current partner before doing it.' Bea (37/Filipina/Heterosexual) relies on asking as well, even though she knows it carries some risk to trust people: 'I trust that they've made good decisions and I ask them. It's stupidity on my part. I should be a lot more cautious than I am but I'm not the smartest when it comes to that. Thank God nothing has come of it so far.' Thus, even when women waffled on their feelings about using this method of determining a partner's safety, they nevertheless resisted the idea of getting tested with a partner.

Theme 4: checking for physical signs of STIs

Three women described that they determined sexual risk by physically inspecting their partner for signs of an STI, often believing that these signs would be immediately visible. Emma (42/White/Heterosexual) said that she conducted a visual check on partners to make sure she was safe: 'I make sure I know the person. And I do a visual inspection. I am the only caregiver to my children. I can't afford to get sick and I don't want anything like that lingering in my life. Yeah, I take real precautions.' Yvonne (41/Mexican-American/Heterosexual) said that she also looked at her partner's genitals to determine her sexual safety: 'I get to know the person first and I kind of inspect it [penis] before I do anything. I just look at it and see if something's weird. If so I'm not gonna do anything.'

As a more elaborate example of relying on physical signs of an STI, Trish (19/White/Lesbian) used her sense of smell and sight to determine if someone has an STI: 'I have put myself in scary situations where I had no idea. I've had a lot of unprotected sex. I try to just see what I see and feel and smell. I've not come across something that was scary but maybe it's not showing right now. I know they're clean based on how they look, like once I get there, I just smell. It's not a very good way to do it.' In this example, Trish hesitated about this approach but did not communicate any other way she knew to ensure her safety.

Theme 5: asking that a partner get tested

As a final theme, three women mentioned that they ask their partners to get tested for STIs as a way to determine their sexual safety. Joyce (21/Filipina/Bisexual) said that she asks partners to get tested but then trusts the results sight unseen: 'I would insist that they get tested if I was going to start having unprotected sex with them. I wouldn't start until they agreed to it and I would be sure that it was something I can safely express that to. I wouldn't see the test results. I'd just trust them to tell me. If they went so far as to go ahead and get the test done then I would trust them to tell me the right thing.' Kathleen (49/White/Heterosexual) said that she once asked a partner to get tested but that she mostly went with her intuition: 'One particular partner I had, we had been together years ago and he resurfaced in my life and he has a particular history that is not good. I made him go and get himself tested, but usually it's just kind of a gut thing. I just go with my gut.' The conflicts between asking for a partner to get tested and relying on trust were quite evident in these descriptions.

There was only one woman in the sample who described getting tested with new partners before having sex. Felicity (20/White/Heterosexual) said that she first asked a partner and then went and got tested together with that person: 'I ask first. And if it ever got to the point where we decided to start having actual sex, we would probably both get tested. Honestly that's something I would want to know.' No other women described routinely getting tested for STIs with current or future partners.

Discussion

This study moved beyond the typical discussions of sexual health and risk found in the current literature – which focus quite heavily on who uses protection, what kind of protection people use, and the risk factors different groups have – and instead relied on qualitative narratives about how women assess risk, danger, and safety of potential sexual partners with regard to STIs. These narratives help to nuance the research on birth control, condom use, and risk-taking by helping us to understand how women weigh, evaluate, and make decisions about risk. Building on previous

qualitative work about women's attitudes about condom use and sexual safety (Cleary et al., 2002; East et al., 2011; Rosenthal et al., 1998; Watson & Bell, 2005), this study highlights women's deep ambivalence about even *thinking* about sexual risk. We can also see the way that gender, power, and intersectionality inform who feels that they can (or should) ask about STIs or, more uncommonly, about getting tested for STIs. In all, these narratives present a rather bleak picture of sexual safety and reveals the ways that women routinely put themselves at risk or feel that they cannot adequately prevent or minimise their exposure to STIs. They say, again and again, that they 'know they should do better' at this but still nevertheless engage in risky sexual behaviours.

This study showed a vast range of diversity in sexual health knowledge in particular, with a fairly sizeable amount of misinformation circulating in women's narratives about how they would know about sexual risk. For example, the belief that the police would notify her if a partner had HIV/AIDS (Sofia), or the notion that one can visibly see or smell an STI on a partner (Trish, Yvonne) reveal just how much misinformation women have internalised about their sexual health. As a more nuanced version of this, women's notion that they can intuit or trust a partner about their STI status – in one case combined with a woman herself admitting to deceiving partners about having herpes (Lila) – shows the risky nature of many women's sexual encounters. Trust and intuition rely on people knowing their STI status and sharing that openly, which often does not occur. (Many people discover they have an STI long after symptoms first appear.) In all, sexual health knowledge was quite limited among this sample of women.

Additionally, these data reveal much about the relationship between gender and power. Who feels entitled to ask about STIs, and women's fears about speaking about the topic, maps onto previous research that consistently shows that women from lower status groups (e.g. women of colour, poorer women, etc.) have more unprotected sex than higher status women (Amaro & Raj, 2000; Kaestle, 2009). Perhaps women only ask about STIs when they feel they have the power to do so in the relationship; those women on more tenuous grounds with a partner, or those women who feel they would hurt their partner's feelings, might be less likely to discuss it. A full three of the five themes involved *no conversation* at all about STIs: avoidance, blind trust, and looking for physical symptoms of STIs all allow women to avoid a direct conversation. The 'trusting a partner to tell the truth' theme involves at least the question being posed, and the 'getting tested' theme was the least common among all five themes. Having conversations about risk and safety is clearly difficult and painful for many women, even to the point that they avoid it altogether.

On a more hopeful note, these data suggest that many women recognise that they 'should do better' at assessing sexual safety and risk, and that public health interventions may have important inroads for women across demographics. I would argue, based on these narratives, that learning about sexual risk prevention also means that people need to hear strategies for approaching the conversation about STIs and getting tested; perhaps tools for communication will be as important as tools for understanding STI transmission and risky sexual behaviours. We hear again and again in these narratives the story that women feel guilty, ashamed, or know that they should be more attentive to their sexual health; this suggests that they may be open to learning more about STI prevention if they were given such an opportunity. Thinking about danger, 'disease,' and infection during sexual encounters is difficult, but if sex educators work to make it more normative, they can have a lasting impact.

These data also suggest that the lack of sex education in Arizona has largely left women without the tools to understand, evaluate, and assess sexual risks, and that the introduction of basic mandatory sex education could impact women's ability to talk about and understand STI risk (Dworkin et al., 2017). Beyond the mere understanding of sexual health, however, are the ways that women often lack the tools to *ask for* STI testing, or to normalise discussions of sexual health with partners. These power dynamics could in part be mitigated by comprehensive sex education that includes content about sexual communication, power, desire, and gender (Stranger-Hall & Hall, 2011).

Limitations and future directions

Certain research decisions may have affected this study's results, as the choice for wording the interview questions may have captured some, but certainly not all, of the facets of how women determine the sexual safety and risk of potential partners. For example, because the questions preceding the question about sexual safety involve discussions of birth control and whether they have ever had an STI, participants may have been more aware of their risky behaviour than if I had only asked about the sexual safety question. Future studies could more closely assess women's ideas about how they decide to use condoms (or not), how they converse with partners about sexual safety, and specific questions about why they do not get tested or ask partners to get tested. Researchers could also look at how women perceive their own and their partner's power in the relationship and how this impacts such conversations about STIs. Looking at the interplay between pregnancy avoidance and STI-prevention conversations and behaviours could also prove useful.

Future research could also specifically target sexual minority women to discuss STI prevention given that social scripts about gender and power may be different for sexual minority women. More research on the implications of these findings to the concept of sexual risk-taking and sexual risk assessment are also needed; researchers could perhaps use quantitative data to better generalise findings about how, and in what ways, women might minimise their imagined risks when having sex with new partners. Finally, while this study drew upon a sample far too small to make specific conclusions about race, class, and sexual identity, it did seem notable that because so much of the previous research has found that women of colour and lower-socioeconomic status women often have more unprotected sex, research could more specifically focus on why these differences emerge. More information about power, coercion, communication, and sexual safety is needed.

Ultimately, this study shows that women have a vast amount of misinformation about their sexual health, combined with avoidance and evasiveness about getting tested for STIs. The difficulty in having frank conversations about sexual health, combined with women's different levels of openness and entitlement to ask about STIs, suggests that sex educators face serious challenges in designing sex education curricula that give women the tools they need to protect themselves from STIs with new partners. This study raises several questions: Why do women avoid direct conversations about STIs and how could sex educators intervene to make this easier and more intuitive? If women rely on magical thinking about STI prevention as adults (e.g. 'just knowing someone is clean' or believing that soon everyone will have herpes), what other public health measures might be useful or helpful to intervene about such thinking? Finally, how do power, status, entitlement, education, and hegemonic masculinity intertwine in women's assessment of sexual risk? Perhaps most clearly this study shows that STI prevention is of course not just a health issue but also one with deep implications for social justice work.

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