



Published in final edited form as:

Women Health. 2019 March ; 59(3): 305–317. doi:10.1080/03630242.2018.1452836.

Examining the Contraceptive Decisions of Young, HIV-Infected Women: A Qualitative Study

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Abstract

This study qualitatively examined factors that influenced contraceptive choices in a sample of young, HIV-infected women. Individual qualitative interviews were conducted among 30 vertically- and horizontally-HIV-infected women ($n = 26$ African American) from the ages of 14 to 24 years (*Mean* age = 20.9 years). We recruited sample groups with the following characteristics: (a) current contraceptive/condom use with 1 child ($n = 11$); (b) current contraceptive/condom use with no children ($n = 12$); and (c) no current contraceptive/condom use with no children ($n = 7$). A semi-structured interview guide was used to ask participants about factors influencing past and current contraceptive choices. Individual interviews were digitally recorded and transcribed verbatim; analyses to identify core themes were informed by the Grounded Theoretical approach. Young, HIV-infected women did not identify their HIV serostatus or disease-related concerns as influential in their contraceptive decisions. However, they reported that recommendations from healthcare providers and input from family and friends influenced their contraceptive choices. They also considered a particular method's advantages (e.g., menstrual cycle improvements) and disadvantages (e.g., increased pill burden) when selecting a method. Findings suggested that HIV-infected young women's contraceptive decisions were influenced by factors other than those related to their infection.

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Keywords

Contraceptive decision making; HIV; young women; United States

Introduction

Approximately one quarter (23%) of individuals living with human immunodeficiency virus (HIV) in the United States (U.S.) are women, with a majority (84%) acquiring infection through heterosexual contact (CDC 2015, The Henry J. Kaiser Family Foundation 2014). Young, HIV-infected women experience elevated rates of unintended pregnancies, sexually transmitted infections (STI), and are at risk for transmitting HIV-1 to uninfected partners and offspring (Kalichman, Pellowski, and Turner 2011, CDC 2007, Campbell et al. 2009). HIV-infected women's decisions regarding contraceptive practices may be influenced by several unique factors, which include their current health status, serostatus disclosure, partner's HIV serostatus, and concerns for mother-to-child transmission (MTCT) of HIV (Magalhães et al. 2002, Massad et al. 1995, Massad et al. 2007). However, a paucity of research exists characterizing factors that influence contraceptive practices among young, HIV-infected women in the U.S.

Most research in this area has focused exclusively on adult women. One line of research has examined changes in contraceptive practices following HIV diagnosis (Magalhães et al. 2002, Massad et al. 2007). For example, among a Brazilian cohort of HIV-infected women, increases in condom use and tubal ligation were observed after HIV diagnosis and decreases in use of birth control pills, intrauterine devices (IUD), and withdrawal (Magalhães et al. 2002). Another study from the U.S., reported increased dual method use (condoms in conjunction with hormonal contraceptive methods) following HIV diagnosis (Massad et al. 2007). Other research conducted in the U.S. has explored potential differences in condom use between HIV-infected and uninfected women, reporting inconsistent results. One study found no differences in frequency of condom use between HIV-infected and uninfected women (Massad et al. 2007), which contrasted with an earlier study suggesting more consistent condom use among HIV-infected women compared to uninfected women (Moore et al. 2001).

Few studies have examined the contraceptive practices of young, HIV-infected women. One study found that condoms were the most frequently used form of contraception in this group, followed by injectable contraceptives alone, then condoms used in conjunction with either injectable or oral contraceptive methods (Belzer et al. 2001). Condom use practices among young, HIV-infected women may vary based on route of HIV acquisition. One study among young HIV-infected women compared the frequency of unprotected sex among those who were horizontally-infected (behaviorally) versus vertically-infected (mother-to-child); this study found that the horizontally-infected women were more likely to have unprotected sex, and that vertically-infected women were less likely to engage in unprotected sex compared to the HIV-uninfected women (Carter et al. 2013). Qualitative results have also suggested that some vertically-HIV-infected young women may insist on consistent condom use, while other vertically-infected young women may experience challenges with HIV status

disclosure and communication about condoms that result in deferring condom use with their male sexual partners (Marhefka et al. 2011).

Young women's knowledge and beliefs related to contraceptive efficacy, safety and potential interactions with antiretroviral (ARV) medications may also influence their contraceptive practices. Some may be mindful that contraceptive methods do not protect against HIV/STI transmission or acquisition or believe that some hormonal contraceptive methods may interfere with their ARV medications or increase HIV transmission risk to partners and may be more inclined to use condoms alone (El-Ibiary and Cocohoba 2008, Heffron et al. 2012, Massad et al. 2007). Apprehension regarding HIV disclosure may also deter young women from having such discussions with their partners, in turn decreasing the likelihood of condom use (Marhefka et al. 2011, Nöstlinger et al. 2010, Carter et al. 2013). Additional relationship factors, including poor partner communication, the belief that a partner has other sexual partners, older partner age, longer relationship duration, and the perception that a male partner is also HIV-infected have also been associated with decreased condom use in young, HIV-infected women (Clum et al. 2012, Sturdevant et al. 2001).

In summary, research examining factors that influence contraceptive decisions among young, HIV-infected women has been limited and has typically focused on condom use practices, with a paucity of qualitative studies. A qualitative approach may provide greater insight into contraception decision-making processes. Therefore, the primary aim of our study was to examine factors that sexually active, young, HIV-infected women reported influenced their contraceptive choices using a qualitative approach. We examined contraceptive decision-making among a sample with different current contraceptive practices (i.e., sub-samples who were and were not currently using a contraceptive method) and among those who were and were not caring for a child. Thus, our approach was designed to facilitate an in-depth understanding of determinants of past and current contraceptive practices to inform future contraceptive counseling practices for HIV horizontally-infected (behaviorally) and vertically-infected (mother-to-child) young women.

Methods

Participants

Recruitment and informed consent—HIV-infected, female patients ($N=30$) were recruited during outpatient medical visits at a comprehensive pediatric and adolescent HIV clinic in Atlanta, Georgia through a two-phase process. During the first phase of the study (conducted from November, 2013 until August, 2015), patients ($N=103$) completed a 30-minute audio computer assisted self-interview (ACASI) assessing their contraceptive practices, sexual behaviors, and knowledge, attitudes, and beliefs regarding pregnancy and STI/HIV prevention. Eligibility requirements for the ACASI study component were: (a) receiving care at the clinic, (b) female, (c) aged 14-30 years, and (d) able to read English and willing to provide informed consent. Exclusion criteria included: (a) currently pregnant or (b) current incarceration. For the first study phase, 158 patients were approached. Thirty-six patients declined participation, and 19 patients did not meet eligibility criteria; 103 patients consented and provided complete survey data (74% of eligible patients completed the initial ACASI study phase).

The ACASI was administered in a private room within the clinic. Additionally, participants' medical charts were reviewed to abstract information on most recent HIV viral load and CD4 T-cell count as well as sexually transmitted infections diagnosed within the last year. Patients who completed the ACASI were informed about the second study phase involving a single one-on-one qualitative interview to understand contraceptive decision-making and, if interested, were screened for eligibility. Eligibility requirements for the qualitative study component were completion of the initial ACASI study phase and reporting penile-vaginal sexual activity during the past 12 months. Of the 103 participants from the initial ACASI study phase, six declined interview participation, and 56 were not eligible for the interview. Thus, 41 were interested and eligible to participate in the second study phase; a total of 30 participants consented and completed the individual interview. Additionally, our recruited sample had the following characteristics: (a) current contraceptive/condom use with 1 child ($n = 11$); (b) current contraceptive/condom use with no children ($n = 12$); and (c) no current contraceptive/condom use with no children ($n = 7$). We also sought to recruit a sub-sample that reported no current contraceptive/condom use and that had one or more children, but we were unable to recruit any participants meeting these criteria.

All participants provided written informed consent to participate in the study. All study procedures were approved by the Emory University Institutional Review Board (IRB), the Centers for Disease Control and Prevention IRB, and the Grady Health Research Oversight Committee. Methods for the second qualitative study phase are detailed in what follows.

Data Collection

Demographic characteristics and HIV infection route—For descriptive purposes, participants reported their age, racial/ethnic background, and current education and employment status. Participants also self-reported the route of HIV infection with responses dichotomized to indicate whether the participant was horizontally-infected (behaviorally) versus vertically-infected (mother-to-child).

Interview procedures—Individual interviews were led by trained female interviewers who received qualitative interviewing training from the first author (XX), a licensed clinical psychologist with experience conducting qualitative research with HIV-infected individuals. In accordance with sample size recommendations to achieve saturation of themes (e.g., 15 ± 5 participants, Kvale 2008; 20 to 30 participants, Cresswell 1998), we recruited a total sample size of 30 participants. A semi-structured interview guide was used. The key objective of the study was to ask participants about their contraceptive history and factors influencing their past and current contraceptive choices and practices (a copy of the interview guide is available upon request to the first author). Interview questions were tailored based on sampling group characteristics (i.e., whether the participant was currently using a contraceptive method; whether the participant had children). For example, participants who were not currently using a contraceptive method were asked, "I'm sure there are times when you wanted to avoid pregnancy and thought about using a contraceptive method or birth control. Please tell me about your past experiences with contraceptives... Why aren't you using a method now?" In contrast, those who were currently using a contraceptive method were asked, "You told me you are currently using

[method(s)], how did you come to choose that method(s)?". Each interview was digitally recorded and transcribed verbatim via a professional transcription service and all transcripts were reviewed for accuracy.

Data reduction and analysis

Interview transcripts were used to develop a structured codebook and subsequent analyses were informed by the Grounded Theoretical approach (Strauss 1987, Strauss and Corbin 1998). Preliminary analyses were performed by relying predominantly on a set of deductive codes that represented the initial study objectives as outlined in the individual interview guide. Analyses included the identification of key themes in the data, segmenting text, and applying codes representing each theme to each text segment. We used open coding, examining each line within a transcript to increase the likelihood that identified codes and themes were grounded in the data. Analyses also employed a memoing approach to make annotations about the data content and patterns that emerged over the course of data analyses to identify core categories and sub-categories within the data. We then engaged in a systematic retrieval and review of data by theme to characterize themes and relationships between themes to refine the coding approach further. Using the initial classification system, two coders (XX, XX) coded a randomly selected transcript separately. The initial coding classification scheme was then further refined based on coding discrepancies and discussion of potential revisions for the coding structure using a standard iterative process (MacQueen et al. 1998, Taylor and Bogdan 1998). Once the coding classification system was finalized, a structured codebook was created. The transcripts were then uploaded into NVivo 11 (QSR International 2010) in which two independent raters (XX, XX) coded all of the interview transcripts using the finalized codebook. Any discrepancies in the coding were resolved by the lead author until no disagreements occurred between coders (XX). The quotations presented were selected because they best typified each of the identified themes in the data.

Results

Participant Characteristics

Twenty-six participants (86.7%) self-identified as African American, three (10.0%) as Caucasian, and one (3.3%) as 'other' racial/ethnic background. Participants' ages ranged from 14 to 24 ($Mean = 20.9$, $SD = 2.3$) years. The majority (66.7%) were not currently enrolled in school or college. Approximately 66.7% percent were employed, working an average of 28.7 hours per week ($SD = 14.8$ hours). More than half (56.7%) reported acquiring HIV through vertical transmission, with the remaining reporting horizontal transmission.

Current Contraceptive Method Use

In accordance with our sampling approach, a subset of participants reported no current contraceptive method use ($n = 7$). Among those in the sampling groups reporting current contraceptive/condom use ($n = 23$), the most frequently reported contraceptive method was depot medroxyprogesterone acetate (DMPA; brand name Depo-Provera), used by 56.5% ($n = 13$). Condoms were the second most frequently used primary method ($n = 5$, 21.7%). Few participants had an IUD ($n = 2$, 8.7%), contraceptive implant ($n = 1$, 4.3%), or used birth

control pills ($n = 1$, 4.3%); one participant reported using both DMPA and birth control pills due to DMPA-associated bleeding ($n = 1$, 3.3%).

Factors Influencing Contraceptive Method Use

HIV Serostatus—The majority of participants did not identify HIV, route of HIV acquisition (i.e., vertical, horizontal), or concerns about mother-to-child transmission as factors that influenced their contraceptive decisions or that specific contraceptive methods would be inadvisable given their HIV serostatus. As illustrated by these two quotes, participants typically noted no distinction between their contraceptive choices and those of their uninfected peers.

Because HIV is – doesn't determine whether you're going to get pregnant or not, so it doesn't stop anything. So I think everybody should take caution and contraception. [Age 22; Current contraceptive/condom use with 1 child]

Just because I'm HIV positive, and they're not, doesn't mean that they don't have to or have to use any type of birth control. It's the same. [Age 22; Current contraceptive/condom use with no children]

Due to concerns regarding HIV transmission to uninfected partners, two participants noted that condom use in conjunction with other pregnancy prevention methods was more important relative to their uninfected peers.

Just 'cause my friends, they just use birth control without condoms. But I like to use both, just in case. And plus, HIV, I don't want to spread it at all. Even though I'm undetectable, I just don't like to take the risk. [Age 20; Current contraceptive/condom use with no children]

The majority of participants viewed their contraceptive options as being the same as young, HIV-uninfected women and did not identify HIV as necessarily influencing their contraceptive choices. However, a minority of individuals expressed concerns about the use of certain contraceptive methods (i.e., birth control pills, IUD) due to their HIV serostatus or use of ARV medications. Three participants stated their belief that they could not use hormonal birth control pills due to concerns about potential interactions with their ARV medications. One participant also reported that she did not think she could receive an IUD because of her HIV serostatus stating, "Because if you have HIV you can't get nothing implanted in you because it's going to have a bigger risk" [Age 23; Current contraceptive/condom use with 1 child].

Role of health care providers—Participants described interactions with their healthcare providers as an important influence in their contraceptive decisions. Most participants reported that they received their reproductive health services from the pediatric and adolescent HIV clinic, while a few received reproductive health services from another clinic or provider. Participants indicated that discussions regarding pregnancy prevention and risks associated with HIV transmission occurred routinely during most clinical visits and that provider recommendations for specific methods were often instrumental in their contraceptive decisions. Some participants reported that providers recommended contraceptive methods because of their ARV regimens. One young woman noted that her

provider "...really recommended the Norplant or the IUDs because they really don't interact with my medicine" [Age 17; Current contraceptive/condom use with no children]. Providers who engaged in discussions regarding specific factors for participants to consider in selecting a contraceptive method were perceived as particularly impactful.

Because he asked me what do I do on a daily routine, and how do I feel about this, or how do I feel about adding another pill, or how would I feel if I missed the pill, and I might still get pregnant from missing one pill, and I was like, "What?" No, I was like, "I'm pretty busy, so since the baby and work and then the boyfriend and the house," it was like, "I'm pretty busy." So, if I could get something that I don't really have to remember about all the time but I know I have it basically then I'd like to try that method. And that's when he was saying it's either Mirena or – he mentioned another one. But he told me to do research on them first and then come back when it was time because I had to wait six weeks anyway and let him know what I had made my decision. [Age 24; Current contraceptive/condom use with 1 child]

Health care providers who gave information about different contraceptive options and potential advantages of long acting methods often figured prominently in the participants' decisions to select these methods.

She told me it [IUD] lasted ten years. That sparked up my conversation there. That grabbed me there. Ten years. Talk more about this; ten years. I mean like come on, if you hear something that will help you from getting pregnant for a full ten years, I'm on that one. [Age 24; Current contraceptive/condom use with 1 child]

I had heard about it [contraceptive implant]. My doctor explained a little bit about different birth controls, and she told me about this one. I really thought that it was the easy one to go with...So I decided I wanted something new, so I went ahead and got the Implanon. She told me how easy it was to get it in, and how painful it wasn't gonna' be. I went ahead and got it. [Age 22; Current contraceptive/condom use with no children]

While most described a collaborative interaction with providers regarding contraceptive options, a small minority of participants indicated they felt as if their provider made the decision for them. This sentiment was expressed by two participants regarding their use of DMPA.

I didn't decide to use Depo. My doctor decided that for me, and I don't use condoms because I'm allergic to latex and I just don't like the feeling of those condoms. [Age 23; Current contraceptive/condom use with 1 child]

Well it really wasn't my choice to be on the Depo. It was my doctor's to prevent pregnancy. [Age 22; Current contraceptive/condom use with no children]

Overall, participants identified their health care providers as central with regard to their contraceptive decisions. Providers who gave information that included personalized recommendations or the advantages of particular contraceptive methods were particularly impactful in participants' contraceptive decisions.

Influence from family and friends—Positive experiences with a particular contraceptive method by participants' family or friends influenced selection of a given contraceptive method. Two participants described that they considered friends' or a family member's experience before selecting an IUD as follows.

...She actually has a little boy but she had used a Mirena, and then I was telling her that I was thinking about [using Mirena] – this is probably two weeks after I had my baby, asking her if she was on birth control and then she was saying yeah, she was using the Mirena. And I asked about side effects and all that. And she said it's been working pretty good for her. But then I had somebody else that said it didn't work for them, but you just have to try to see if it works for you. So I was like, "Well, let me just try it and see." [Age 24; Current contraceptive/condom use with 1 child]

What made me really come down with it is because my niece has it [an IUD]. [Age 24; Current contraceptive/condom use with 1 child]

Similarly, friends who shared negative experiences with a given method were also influential. When describing the role of friends' past contraceptive experiences, one participant remarked:

"I guess my friends, well my friends experience with it was kinda' negative, so they're like I don't really like the pill, they told me about other options" [Age 23; Current contraceptive/condom use with no children].

Some participants noted that they discussed contraceptive options with family members, who provided information or encouraged them to acquire additional information about their contraceptive options. One participant commented that her family encouraged her to learn more about available contraceptive options noting,

"They [family] pretty much told me to do my research on the different types of birth control and then just go from there" [Age 17; Current contraceptive/condom use with no children].

Participants also noted that discussions with family members regarding contraception resulted in additional conversations regarding their current sexual activity. In the wake of her admission that she was having sex, one participant said that her mother was "shocked" and remarked,

"you having sex?" I said, yeah. 'Well, you going to get on Depo, 'cause I don't want you to get pregnant too quick.' I said, 'okay'" [Age 23; Current contraceptive/condom use with no children].

In like manner, the decision to start a contraceptive method was sometimes initiated by family members. Two participants indicated that their mothers (mom and foster mom) were responsible for the decision to start DMPA. Family members, particularly participants' mothers, were seen as a source of information and support to get information about different contraceptive options, but few participants indicated that their mother made the decision to initiate contraception use.

Consideration of a contraceptive method's advantages and disadvantages—

Participants talked about contraceptive methods' perceived advantages and disadvantages, typically from their previous contraceptive experiences, and that these were important considerations in selecting a particular contraceptive method. The most frequently cited advantages included menstrual cycle improvements, ease of use, and effectiveness level for preventing pregnancy and/or STI/HIV. Methods that either made young women have more regular menstrual cycles or stopped their menstrual periods were viewed favorably.

What I like about the pill is that it – it regulates my cycle. [Age 17; Current contraceptive/condom use with no children]

What I like about the pills is ever since I've taken it have stopped my period. [Age 22; Current contraceptive/condom use with no children]

Some participants noted that contraceptive methods other than daily birth control pills were preferable due to their ease of use and not requiring an additional daily pill.

I get it [IUD] because I don't want to take a pill, another pill every day... it's like you don't have to really remember anything. It's just there. You know it's there. You've just got to remember that it's there because it only lasts for like five years and then you've got to get it switched out with another one. [Age 24; Current contraceptive/condom use with 1 child]

Methods, particularly long-acting reversible contraceptive methods, that the women experienced as highly effective at preventing pregnancy were perceived as more desirable. One woman commented on the effectiveness of her contraceptive implant, stating, "I ain't got pregnant in a minute. [laughs] It's been three years" [Age 19; Current contraceptive/condom use with no children]. Additionally, the women cited their desire to use methods that provided both effective pregnancy prevention and protection from STI/HIV.

"I guess that they [condoms] prevent pregnancy and prevent, you know, the transmission of STDs and HIV and stuff." [Age 22; No current contraceptive/condom use with no children]

Some participants also noted that perceived disadvantages of particular methods were reasons that dissuaded them from using a given method. The most frequent method disadvantages were those viewed as requiring a high level of adherence (i.e., daily birth control pills), undesirable menstrual cycle changes, and side effects including weight gain, mood changes, menstrual cramps, and nausea. The most prominent concern raised by participants was challenges adhering to use of birth control pills on a daily basis.

The pill I didn't like...because I kept forgetting to take it every day. So I stopped taking those. [Age 19; Current contraceptive/condom use with no children]

Because it's hard to keep up with, and, you know, you have to do the same time every day. [Age 22; No current contraceptive/condom use with no children]

Young women also noted that certain menstrual cycle changes were undesirable, including increased bleeding or irregular periods.

It [DMPA] kind of messed me up or should I say since I've been on it my period's been irregular and I have bled too much. [Age 22; Current contraceptive/condom use with no children]

I did Depo twice. It made me bleed for three months both times. She [medical provider] just tried to get me to get another one. No. I don't want to bleed for three months. Are you crazy? I think she is. [Age 21; Current contraceptive/condom use with 1 child]

Additionally, some participants objected to amenorrhea while using contraception.

I guess like having a period is like comforting, you know? [Age 23; Current contraceptive/condom use with no children]

It was like, yeah, no cycle, but my body's not cleaning itself so that's not good. [Age 23; Current contraceptive/condom use with 1 child]

Weight gain was perceived as a negative side effect, particularly among those who had current or past DMPA use. Reflecting on her current experience while on DMPA, one young woman said,

"I gained weight, and my boobs got bigger, and I was moody. So, no nothing really positive" [Age 23; Current contraceptive/condom use with no children].

Discussion

Despite previous studies suggesting unique concerns influencing contraceptive decision making in HIV-infected women (Magalhães et al. 2002, Carter et al. 2013), the majority of participants in this study perceived no differences between themselves and their uninfected peers in factors affecting their contraceptive choices. However, a few participants reported their beliefs that certain contraceptive methods (IUD, birth control pills) were not advisable for young women with HIV. Additionally, a minority of participants highlighted the increased importance of condom use in conjunction with other forms of contraception to reduce the potential for sexual HIV-1 transmission or acquisition of other STIs.

Evidence is conflicting regarding factors that may influence condom use among HIV-infected women. For example, one study reported reduced condom use with a steady, partner regardless of serostatus (Simoni, Walters, and Nero 2000), while another indicated that HIV-infected women may be less inclined to use condoms with seroconcordant male partners in particular (Liu et al. 2011). Findings from this study did not suggest that participants' partners or characteristics of their current relationship influenced use of condoms or other contraceptive methods.

The majority of women participating in this study received reproductive health services from a pediatric and adolescent HIV clinic. Participants indicated that provider recommendations for specific methods, particularly when recommendations were informed by a participant's individual concerns were influential in subsequent contraceptive method selection. Furthermore, providers who presented information regarding potential advantages of long-acting contraceptive methods appeared to be particularly influential for uptake of these

methods. However, provider recommendations may have resulted in a small subset of participants who attributed their current contraceptive method to their provider's choice, rather than a collaborative decision making process. These results highlight potential considerations for future provider-delivered interventions targeting contraceptive practices in combination with STI/HIV prevention methods that could be delivered in a clinic setting; interventions may benefit from inclusion of individually-tailored information about different contraceptive options and their advantages and disadvantages. Thus, our efforts may need to shift toward developing and evaluating interventions to emphasize dual-method use and consider the integration of new preventive strategies to overcome the persistent challenges posed by inconsistent condom use. Additionally, results suggest that improving the integration of reproductive health services within HIV care settings coupled with provision of ongoing training for HIV care providers regarding the most current contraceptive recommendations for HIV-infected adolescents (Kourtis, Mirza, and AIDS 2016) may facilitate young HIV-infected young women's access and uptake to long acting reversible contraceptive methods.

The young, HIV-infected women who participated in this qualitative study often described their family or friends as playing a role in their contraceptive decisions. Both positive and negative experiences with individual contraceptive methods among their family and friends were influential in subsequent contraceptive choices. In some cases, the young women described their mothers as advocating for contraceptive use after learning of sexual activity by their daughters. Such discussions at times also served as an entrée to conversations between the women and their family regarding initiation of sexual activity and, in some cases, prompted mothers to seek out contraception for their daughters. While some prior studies have suggested that young, HIV-infected women may defer to their male partner on decisions to use condoms or other forms of contraception (Soet, DiIorio, and Dudley 1998, Clark et al. 1997), the results of this study suggest that close friends and family members' contraceptive experiences may be more influential in their contraceptive decisions. Indeed, despite asking explicitly about the role of partners in contraceptive decision making, participants did not endorse that partners significantly influenced their contraceptive decisions.

As observed in non-infected adolescents, young HIV-infected women described weighing a contraceptive method's advantages and disadvantages when selecting a particular method. In large part, the young women evaluated these factors based on prior experiences with a given method. Contraceptive decision-making did not appear to differ based on whether participants were caring for children or not nor based on concerns related to mother-to-child transmission of HIV-1. Instead, past contraceptive experiences, coupled with perceived benefits and disadvantages of a given method were more typically described as key contributors to participants' decisions to use current contraceptive practices. Participants sought methods that were easy to use, provided improvements to their menstrual cycle, afforded effective pregnancy prevention and STI/HIV protection, and had few side effects. Of note, the consensus was that birth control pills were not favorable, given past adherence difficulties or desire to avoid additional pill burden with their ARV regimens.

Strengths and Limitations

To our knowledge, this is the first study to examine qualitatively factors that may influence young, HIV-infected women's contraceptive decisions in the U.S. By recruiting unique samples of young, HIV-infected women with and without children who were either currently using a contraceptive method or condoms or not, our study included young women with different contraceptive and parenting experiences. Interpretation of findings should be considered within the limitations that are inherent to qualitative research. First, findings may not be representative of contraceptive decisions made by other young, HIV-infected women receiving care in different clinical settings, which may limit the transferability of study findings. Second, because participant input was generated based on a structured interview guide, this format may have shaped the type of input that was obtained. However, participants candidly shared diverse experiences, suggesting that the interview guide facilitated a discussion on a range of factors affecting their contraceptive decisions. In addition, given our purposive sampling frame, women who were willing to participate in the individual interviews may have had a unique perspective regarding their experiences with contraceptive decision-making that is not generalizable, but we have no reason to believe that the sampling frame affected individuals' decision to participate in the study.

Conclusions and Practice Implications

The majority of the young, HIV-infected women who participated in this qualitative study reported receiving reproductive health care services via the pediatric and adolescent HIV clinic, and that medical providers were particularly influential in their contraceptive choices, especially providers who provided individualized recommendations. Clinic settings providing comprehensive HIV care may be optimal for individualized interventions to enhance acceptability of long-acting reversible contraceptive methods that have more advantages and fewer disadvantages compared to shorter-acting contraceptive methods. Such interventions may also benefit from inclusion of content that addresses the role of young, HIV-infected women's family and peer network in influencing their contraceptive practices along with strategies to increase consistent condom use to decrease HIV-1 transmission risk.

Acknowledgments

This research was supported by 3U48DP001909-04S4 from the Centers of Disease Control and Prevention to Jennifer L. Brown, Rana Chakraborty, and Lisa B. Haddad (Multiple Principal Investigators). Lisa B. Haddad's effort is supported by the NICHD (1K23HD078153-01A1).

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