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*Original Article*

# Effectiveness of interventions for preventing STIs in women experiencing intimate partner violence: systematic review

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**Abstract. - Introduction:** The aim of this systematic review was to synthesize the available behavioral interventions that have proven effective in promoting safe sexual behavior and the prevention of STIs, including HIV, in women who have experienced some form of violence. It describes some of the characteristics of these interventions and their impact on behavior modification. **Method:** Interventions published from January 1995 to January 2020, indexed in JCR, were included. A systematic review was conducted of the scientific literature included in the databases EBSCO Academic Search Complete, CINAHL, MEDLINE/PubMed, Springer, Web of Science, Elsevier, Dialnet, SciELO, and Google Scholar. The PRISMA statement recommendations and the steps proposed by Holly et al. were followed. Interventions were selected according to the proposed inclusion criteria, and the analyses were synthesized narratively, with the results tabulated. **Results:** Five intervention studies met the established inclusion criteria, all of which were randomized controlled trials. These interventions comprised between one and eight sessions in either individual or group formats, with a duration ranging from ten to 250 minutes. The results showed effectiveness in maintaining safer sexual behavior with condom use. **Conclusions:** Behavioral interventions for STI prevention and the maintenance of safe sexual behavior in women highlight the opportunity to guide research on intimate partner violence and STI prevention, thereby reducing gender-related health disparities.

**Keywords:** Intimate Partner Violence, Systematic Review, Sexually Transmitted Diseases, Sex Education, Sexual Behavior, Woman.



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## 1. Introduction

Intimate partner violence (IPV) and sexually transmitted infections (STIs) are two public health issues that affect women worldwide. IPV refers to any pattern of behavior used by a partner to maintain power and control over the other person in an intimate relationship[1]. Currently, IPV occurs in one out of every three women globally[1,2]. This violence can be physical, psychological, economic, patrimonial, and/or sexual[3-5], leaving severe consequences not only on physical and mental health[5,6] but also increasing the risk of contracting STIs and even being associated with premature death.

According to the World Health Organization (WHO)[2], Borumandnia[7], and Goga[8], violence against women is an endemic phenomenon that saw a worrying increase during the COVID-19 pandemic due to confinement and the suspension of certain support services. In Mexico, 70.1% of women have experienced some form of violence, which saw a substantial rise during the pandemic confinement, from 7,723 cases in 2016 to 10,579 cases in 2021[9-11].

Although IPV can be experienced by both men and women, it has been documented that women suffer from it in a higher proportion[12–14]. The reported figures are generally lower than the actual numbers, as it has been shown that women do not report every instance of violence and may not even recognize it as such. Additionally, they face difficulties in accessing health services[15-18].

Women exposed to IPV not only face an increased risk of acquiring STIs but also of unintended pregnancies and/or repeated abortions[19]. The unequal power dynamics in abusive relationships often make it difficult for women to negotiate the use of contraceptives and protective mechanisms, such as condoms, making the challenge of addressing STIs a global issue. Women who suffer from IPV are in an especially vulnerable group. In this context, various interventions have been developed to address this problem and reduce the risk of STI transmission in this population.

Although IPV is not gender-exclusive, most efforts have concentrated on violence against women[20-21]. According to Basile[22], interventions need to focus on female empowerment to increase their opportunities in economic, educational, and employment aspects. In the same vein, Campbell[23-26] refers to multiple interventions aimed at mitigating the adverse consequences and reducing the harm suffered by women who have experienced violence. Thus, various approaches have been proposed to address this issue, including awareness campaigns and specific interventions, encompassing diverse strategies to prevent STIs and Human Immunodeficiency Virus (HIV) in this vulnerable group. These strategies range from sexual health education, access to health services, and psychological and social support. Despite the potential benefits of these interventions, significant challenges remain, such as confidentiality, safety, and adequate training of health



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professionals, which are critical aspects that must be managed to ensure the effectiveness of any prevention program in this context.

Part of the problem lies in the fact that as long as people engage in risky sexual behaviors, there is a likelihood of STI transmission, including HIV, which not only affects physical health but also impacts life projects, financial situations, and social relationships[27-29]. Today, society considers sexual health a taboo topic, especially when it comes to women. This stigma has severe consequences, as it even renders these issues invisible[30], and suppresses women from seeking help when they experience STI symptoms[29], which can lead to chronic or even fatal problems.

In other words, the shame women often feel is usually a consequence of cultural norms and inadequate sexual education, leading many women to self-medicate or ignore symptoms, resulting in delayed diagnosis and treatment of STIs, which increases the risk of severe complications such as infertility, pelvic inflammatory disease, and/or cancer in cases of untreated STIs.

It is essential that women feel empowered to take care of their sexual health, including regular self-examinations and seeking professional help. The National Women's Health Network[31] points out that a significant percentage of women have never performed a self-examination, as any act related to sexuality or autoeroticism is considered masculine. Some researchers recommend incorporating the concept of empowerment into the development of interventions[32–34]. Campbell[25] mentions that multiple interventions are directed at reducing the harm women have suffered due to IPV. On the other hand, evidence has been documented evaluating interventions for STI/HIV prevention, which focus on reducing risky sexual behaviors that may be associated with drug use. However, there is little evidence documenting the effectiveness of interventions aimed at reducing risky sexual behaviors (RSB) in specific situations like IPV.

Scientific evidence has demonstrated the coexistence of STIs/HIV and IPV. Therefore, due to its incidence, more efforts should be focused on prevention, and it is considered crucial that public health centers on improving women's health conditions, increasing comprehensive sexual education, including the prevention of STIs linked to violence[35,36].

Due to the vulnerability experienced by women who suffer IPV and the consequences on their sexual and reproductive health compared to women who do not, there is an incentive for professionals and the health system to adapt to these current needs where violence has been on the rise. It is crucial to identify interventions that promote health and preserve the protective factors observed in women who are victims of violence. Therefore, the objective of this systematic review was to analyze the



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available interventions to prevent STIs/HIV in young adult women who experience IPV.

## 2. Method

This systematic review was developed using the PRISMA method[37], homogenizing existing national and international information to achieve an adequate approach to the variables, and following the steps proposed by Holly[38], which are described below:

### *2.1 Eligibility Criteria*

The inclusion criteria for this systematic review were as follows: 1) descriptors included in the title and abstract, 2) full-text studies, 3) studies with the objective of preventing STIs/HIV and violence, 4) randomized controlled trial (RCT) design, 5) studies with a comparison group, 6) studies with follow-up results, 7) studies specifically for the female gender, 8) studies involving women aged 18 to 40 years, studies in English, Portuguese, or Spanish, 9) publications from 1995 to January 2020, 10) studies reporting behavior modification in the results, 11) studies describing the intervention.

### *2.2 Search Strategy and Study Selection*

The search was conducted in the following databases: EBSCO Academic Search Complete, CINAHL, MEDLINE/PubMed, Springer, Web of Science, Elsevier, Dialnet, SciELO, and Google Scholar. The descriptors integrated into the Medical Subject Headings (MeSH) and Health Sciences Descriptors (DeCS) were used, along with Boolean operators, making combinations with the following descriptors: "Sexual education" OR "Educational Program" OR "Brief Intervention," OR "Behavioral Intervention" AND "Partner Violence" OR "Dating Abuse" OR "Dating Violence" OR "Couple Violence" AND "Condom Negotiation" OR "Safe Sex" OR "Safer Sex." Additionally, gender and age filters were applied.

A reference manager was used to organize the located references and eliminate duplicate studies. After concluding the identification phase of the studies, a screening of the data was performed by title and abstract, selecting only the articles that adhered to the inclusion criteria. The identified articles were evaluated following the recommendations of the PRISMA guidelines, and the evaluation of the methodological quality of the studies was complemented by the Joanna Briggs Institute's critical appraisal checklist for studies and prevalence, emphasizing the study's objective, applied methodology, research design, and results of the intervention's effectiveness.

Subsequently, the authors reviewed the titles and abstracts of each reference to verify that each abstract met the inclusion criteria, and articles that did not describe the intervention for preventing STIs/HIV in women were eliminated. Furthermore, the methods/methodology and results sections were read to verify adherence to the eligibility criteria. A full reading was



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conducted for each of the interventions that met each inclusion criterion.

Independent coding and extraction of the studies included in the systematic review were carried out, followed by a comparison by each author to achieve greater accuracy and avoid discrepancies in criteria. Characteristics such as the origin of the study, application location, study design, follow-up, intervention modality, sample size, number of sessions, intervention duration, primary and secondary outcomes related to the risk of STI/HIV transmission, acceptability, feasibility, and fidelity of the studies were analyzed.

The methodological quality of the articles was evaluated using the MINCIR checklist[39], which includes the assessment of three domains: Domain 1: study design; Domain 2: population studied with justification factor; Domain 3: methodology used (objective, design, selection criteria, and sample size). The protocol for this review was registered in PROSPERO (547838).

## 3. Results

From the included studies, identification information such as the authors' names, year and country where the study was conducted, study design, sample size, and characteristics of post-intervention measurements were extracted. Finally, an analysis, integration, and interpretation of the intervention studies aimed at preventing STIs/HIV and managing safe sexual behavior in women exposed to violence was carried out. Figure 1 shows the search results, the exclusion criteria for intervention studies using the PRISMA methodology.

During the initial search, 2,753 potentially relevant citations were identified, with 1,432 duplicate citations being removed due to systematic search criteria. This resulted in 1,321 abstracts that were independently selected.

A total of 1,253 citations were excluded for not meeting the inclusion criteria, leaving 68 full-text articles that underwent a more detailed review. Finally, 14 studies met the inclusion criteria. These 14 were further reduced to five articles because not all the characteristics of the intervention implementation were found in the analysis of the descriptions (Figure 1).



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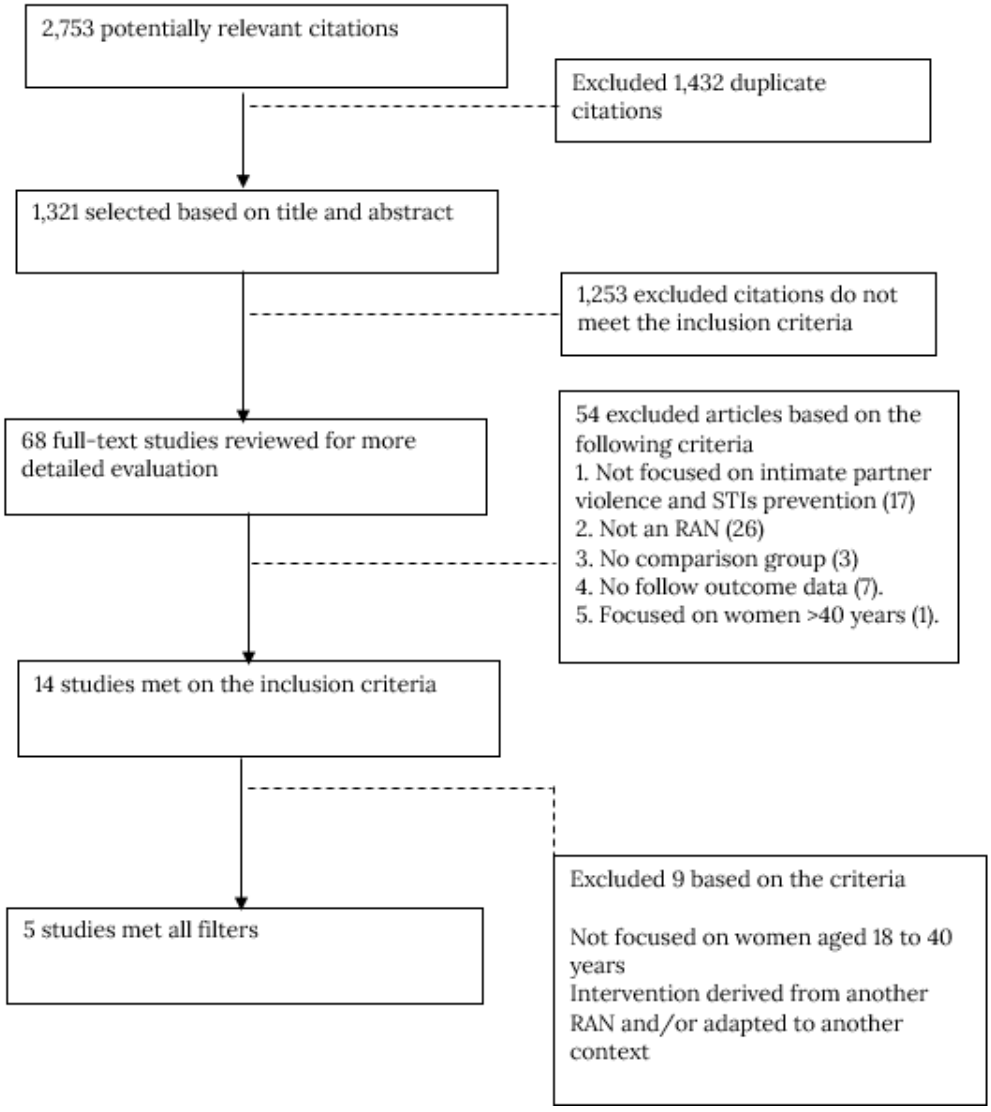


**Figure 1.** Flow chart for STI prevention interventions for women with intimate partner violence.

Regarding the methodological quality of the intervention studies, 100% (n=5) obtained an acceptable quality score according to the MINCIR scale (Table 1), with a score above 18 points being considered acceptable.

Table 1 presents the five selected studies, of which four were conducted in the United States[39-42] and one in Latin America[43]; all studies were randomized controlled trials.



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**Table 1.** Description of intervention programs.

| Author | Delivery | Sessions | Main component | Months of Follow-up | Primary results | MINCIR Score |
|---|---|---|---|---|---|---|
| Mittal[40] | I - G | 8 | Safe sex/condom use negotiation. | 3 | Direct STI/HIV risk, Episodes of unprotected SR, STI knowledge, Safer sex intention, Condom use self-efficacy negotiation skills. | 26* |
| Meléndez[41] | G | 4 or 8 | Communication and empowerment. | 1, 6, 12 | Direct STI/HIV risk, Episodes of unprotected SR, Intention of safe sex, Comfort in communication, Self-efficacy of condom use. | 31* |
| Wingood[42] | I - G | 8 | Risk, vulnerability. | 6 y 12 | Consistent use of condoms, HIV and STI reduction, STI/HIV knowledge. | 35* |
| Villegas[44] | G | 6 | Self-efficacy. | 3 | STI/HIV knowledge, Attitude towards condom use, Self-efficacy for STI/HIV prevention, Vulnerability, Internet use, Internet use, Internet use, Internet use, Condom use. Vulnerability, Internet use. | 23* |
| Jemmott[43] | G | 1 | Self-efficacy, SR negotiation and condom use, Assertive Sexual Communication, Sexual Empowerment | 3, 6, 12 | STI/HIV risk reduction, Drug use reduction, Self-efficacy, Consistent condom use episodes, Condom use negotiation skills. | 35* |

Note: I = Individual, G= Group. SR= Sexual Relationship, STI= Sexually Transmitted Infection, HIV = Human Immunodeficiency Virus.
* Adequate methodological quality according to MINCIR scale (adequate = 18 points).

Below is a description of the identified interventions, with an analysis of each one based on the aforementioned inclusion criteria.

Mittal[40] presents the results of an intervention focused on reducing HIV risks for women with a history of intimate partner violence. This intervention proved promising in addressing the vulnerability of women to violence and STIs, providing a comprehensive approach to women's sexual and emotional health. The intervention was conducted both individually and in groups across 8 sessions. Three individual sessions (1, 3, and 4) focused on psychoeducation regarding relationships, resilience, and empowerment; the remaining five sessions addressed activities centered on STIs/HIV, gender violence, self-protection, and healthy living. The intervention showed efficacy at three months in maintaining safe sexual behavior, communication skills, and condom use skills, as well as reducing anxiety and depression.

Meléndez[41] highlights the importance of negotiating safe sexual practices in the context of intimate partner violence. This intervention was applied in two dosage levels: one group received 4 sessions and the other 8 sessions, covering STI knowledge, motivation, attitudes, beliefs,



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and condom use skills. The intervention demonstrated efficacy in maintaining safe sexual behavior with condom use and increasing self-efficacy in communication up to 12 months post-intervention.

Wingood[42] conducted the AMIGAS intervention, an adaptation of the SiSTA intervention, designed to reduce behaviors that increase the risk of HIV and STI transmission among women living with HIV. The intervention was conducted over a total of 8 sessions, with three individual sessions and five group sessions, incorporating mindfulness meditation exercises and addressing topics such as HIV/STI knowledge, communication skills, condom use, and healthy relationships. The results showed a decrease in STI incidence, improved condom use skills, and maintenance of protected sex up to 12 months post-intervention.

Villegas[44] emphasizes the importance of considering psychosocial and gender factors in the design of interventions for STI prevention in women experiencing intimate partner violence. This comprehensive approach acknowledges the intersectionality of these women's experiences and the need for strategies sensitive to their particular contexts. The intervention was conducted in small groups of 8-10 women, covering topics such as STIs, HIV prevention, negotiation knowledge, couple communication, violence prevention and control, in participatory sessions that included videos, role-playing, and discussions to develop self-efficacy and communication skills. A follow-up was conducted at 3 months, reporting an increase in knowledge levels, positive attitudes towards reducing stigmatization, improvement in negotiation and communication skills, and a reduction in risky sexual behaviors.

Jemmott[43] has emphasized the relevance of behavior theory-based interventions that seek to modify risky behaviors through education, motivation, and the strengthening of negotiation skills in the context of intimate relationships. This perspective focuses on empowering women to make informed decisions about their sexual and reproductive health.

The Sister to Sister intervention demonstrated efficacy in young women for maintaining safe sexual behavior and reducing STI incidence. It is a brief intervention involving group discussions, videos, games, and exercises for STI/HIV reduction, development of correct condom use skills, and sexual relationship negotiation skills. The intervention is conducted in a group setting in a single session. It showed efficacy in reducing risky behaviors, decreasing STI prevalence, and reducing alcohol and drug use during sex, with results persisting at 3, 6, and 12 months follow-up.

## 4. Discussion

In this systematic review, five STI/HIV prevention interventions specifically tested in young women experiencing intimate partner violence were identified. Four of these were implemented in the United States[40-43] and one in Latin America[44].

Globally, the existing literature recognizes the magnitude of the problem[26]. However, while there are studies addressing the



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problem and prevention of HIV, there are few interventions that have been carried out in women who have experienced violence. Therefore, the effects of interventions on women who live or have lived through intimate partner violence are unclear, as there are undoubtedly variables that influence this population group and affect their behavior regarding STI/HIV prevention. Women who suffer intimate partner violence face unique challenges in negotiating safe sexual practices and preventing STIs.

Adolescence is considered a vulnerable and at-risk population group, which is why most studies are conducted in this group. However, there are very few studies directed at adult women. In this sense, it is important to recognize that women experiencing intimate partner violence are also a vulnerable group in terms of STI/HIV transmission due to the characteristics that influence their decision-making.

Systematic reviews have been conducted focusing on HIV prevention, especially in adolescent populations[21,44,45]; however, there are few interventions that aim to prevent STIs in women and in early adulthood[47-50], resulting in limited evidence on STI prevention in this population.

Most of the reviewed articles used different theoretical frameworks to support the design and implementation of the intervention, with the most commonly used being the following: Bandura's Social Cognitive Theory[51], Ajzen's Theory of Planned Behavior[52], and Fisher's Information-Motivation-Behavioral Skills (IMB) model[53,54].

The focal points identified in the articles were: empowerment, self-esteem, barriers to condom use, self-efficacy, negotiation skills, and communication skills. In addition, the study by Villegas[44] included gender roles, machismo, and feminism, while Mittal[40] reinforced the psychoeducational aspect of family and couple relationships. Most interventions combined two or more of these focal points.

The approaches of the interventions were group-based in all five reviewed articles[40-43], with two also including individual sessions[40,42]. It can be deduced that group sessions are more effective, primarily due to the feedback provided among the participants.

The duration of the sessions in the identified interventions varied significantly, ranging from 10 to 250 minutes. It is considered that, in the case of women with multiple responsibilities such as household chores, childcare, work outside the home, among other activities, it is preferable to have shorter sessions to maintain their attention and prevent participant dropout.

The environmental context of the interventions was similar across all five articles; all were conducted in community clinics, and based on the mentioned descriptions, there was geographic diversity. Four studies were developed in the United States[40-43], and only one in South America, specifically in Chile[44]. The majority of the participants were African American and Latina women.

The identified interventions were mainly based on individual behavior change



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mechanisms to reduce the prevalence of STIs/HIV, seeking to address the factors that drive vulnerability to STIs/HIV. The studies by Mittal[40] and Jemmott[43] emphasize the importance of promoting behavior modification from a risk reduction perspective.

All the selected interventions reported positive outcomes for the participants. For instance, Jemmott[43], Wingood[42], and Mittal[40] developed skills for correct condom use and communication skills with partners, achieving successful condom negotiation and a reduction in STI prevalence. Additionally, Meléndez[41] confirmed that the two-level program is considered effective based on participant feedback.

Jemmott's study[42] highlights the fundamental role of negotiation self-efficacy in maintaining protected sexual relations. The life skills training improved self-efficacy, self-esteem, and sexual negotiation[41,42], STI/HIV testing[40,42], and reduced risky sexual behaviors[40-43]. Improved communication skills may have mitigated intimate partner violence[40,42], which could lead to sexual empowerment.

The enhancement of skills may sustain post-intervention outcomes. The improvement in self-esteem, sexual negotiation self-efficacy, and condom use continued to maintain safe and protected sexual behaviors even two years after the completion of the programs[41].

## 5. Conclusions

This systematic review on STI and intimate partner violence prevention has shed light on the need to implement comprehensive interventions that address not only the prevention of STIs/HIV but also intimate partner violence and the structural barriers that contribute to their persistence.

It is crucial to recognize that STI prevention goes beyond the promotion of condom use. While this method is effective, interventions need to be broader and consider factors such as sexual education, access to healthcare services, gender equity, and the empowerment of individuals to make informed decisions about their sexual health.

Intimate partner violence is a public health issue closely related to STIs. Individuals experiencing intimate partner violence are at greater risk of contracting STIs due to a lack of control over their sexual and reproductive health, as well as the difficulty in negotiating safe sexual practices. Therefore, interventions that address intimate partner violence not only improve the emotional and physical health of individuals but also contribute to STI prevention.

It is essential to consider the structural barriers that hinder access to sexual and reproductive health services. The literature indicates that these barriers must be addressed for a better understanding of the phenomenon under study. In this case, factors such as stigmatization, discrimination, lack of economic resources, and lack of education can limit individuals' ability to seek medical care or adopt safe sexual practices. These barriers should be addressed by communities, institutions, and governments to ensure that everyone has access to quality healthcare services.



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The results of this review correlate with the study's limitations. It was previously noted that only one study was located in the Latin American context, which is concerning as violence and STIs/HIV are global factors.

## 6. Declarations

### 6.1 *Author Contributions*

IPVC: Conceptualization, methodology, formal analysis, research, original draft writing, formal analysis, data curation.

RCBM: Conceptualization, methodology validation, formal analysis, writing: review and editing, supervision, visualization, formal analysis, data curation, project management.

RABT: Writing: review and editing, visualization, formal analysis, data curation.

YFP: Visualization, supervision, review.

### *6.2 Conflict of Interest*

The authors declare that they have no conflicts of interest.

### *6.3 Acknowledgments*

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