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Condom use behaviours among 18–24 year-old urban African American males: a qualitative study

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Abstract

The purpose of this pilot project was to develop, administer and assess a brief male-focused and behavioural-driven condom promotion programme for young adult African American males in an urban setting. To achieve the aims of this study, linkages with local community centres were initially fostered and both quantitative and qualitative research methods were employed. Based on relevant tenets of the social cognitive theory and the stages of change model, a series of focus groups were conducted among the target population, recruited from non-traditional urban settings, to identify and further explore their perceived condom use barriers and facilitators in order to support programme development. Specifically, the topical items addressed those young men's perceptions of sexuality and condom use within three broad contexts: general sexual behaviours, condom use behaviours, and the relationship between condoms and substance use. The focus group discussions were audiotaped and the transcribed data summarized and analysed based on those thematic topics. The findings revealed that significant myths, misconceptions and knowledge gaps exist regarding HIV/STD-related prevention, condom promotion and substance use. The findings imply that there is a critical need to develop target group suitable condom promotion programmes in order to successfully promote, foster and sustain condom use among high-risk populations.

Introduction

The risk associated with unprotected sexual intercourse is reflected in the disproportionately high rates of sexually transmitted diseases (STDs), including the human immunodeficiency virus (HIV) infections, especially among young people in the US (Mann et al., 2000;Starkman & Rajani, 2002;CDC, 2001a). Also, there is concern that HIV/STD is increasingly concentrated in urban communities where racial/ethnic minorities, especially African Americans and Latinos, are often disproportionately represented (Kaiser Family Foundation, 2001,2003). In the year 2001, for example, gonorrhoea rates for African American males aged 20–24 years were about 24 times greater than those of non-Hispanic Whites (CDC, 2001b,c). Also, although chlamydia infections are common among all racial/ethnic groups, especially females; yet, minorities continue to consistently account for higher rates. The situation is even more serious for African Americans; among males, the age-specific rates – mainly those aged 20–24 years – were substantially higher than those of all age groups (CDC, 2001b,c).

Despite these alarming statistics, promoting safer sexual practices for racial/ethnic minority males in urban communities remains a major public health challenge, especially regarding effective and consistent condom use (DiClemente et al., 1996;Crosby et al., 2001).

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Accordingly, the National Academy of Sciences and the National Commission on AIDS had recommended that further research be undertaken to elucidate the processes and dynamics that could potentially influence condom use among urban youth (DiClemente et al., 1996). As a call to action, this research study was designed to identify the barriers and facilitators of correct and consistent condom use among urban young adult African American males.

Theoretical foundation

This project was guided by the integration of Bandura's (1994) social cognitive theory (SCT) and Prochaska et al's (1992) trans-theoretical model (TTM). Both theories have been previously used in HIV/AIDS prevention research (Kirby et al., 1994). When collectively applied to sexual behaviours, both theories hypothesize that behaviours such as preventing HIV/STD can be supported by an understanding of what must be done to avoid HIV/STD (e.g. consistent condom use), a belief in the anticipated benefit of avoiding unprotected sexual encounters (e.g. decrease chance of infections), and a belief that such skills can be effectively used in risky sexual contexts and situations (Kirby, 2001).

Study goal

In this paper, we report the findings from our qualitative study, the purpose of which were to (1) identify and explore condom use barriers and facilitators (e.g. contexts to use or not use condoms), (2) assess the program theories (e.g. are urban males in a pre-contemplation stage), and (3) identify and explore the perceived condom use behavioural skills of the study population.

Methods

Eligibility criteria

Participants were eligible for the study if they were 18–24 year-old African American males who access health services from one of four designated community centres on Chicago's South Side and at risk of HIV/STDs (e.g. self-report of unprotected sex, inconsistent condom use or multiple sexual partners in the past 3–6 months). Also, participants were expected to understand English at the 6th grade level.

Enrollment procedures

We recruited participants from hang out spots (e.g. street corners, game centres) within the study's catchment areas. We also used a mobile van with a television set showing musical videos and a sound system playing rap music for recruitment. Individuals we approached were informed about the goals of the research study and for those with interest, private venues were secured to determine their eligibility based on a standardized form that collected basic data on age, community and evidence of high-risk sexual behaviours. For eligible individuals, tracking data (e.g. phone numbers, hang out spots) were obtained and appointments scheduled within 24–48 hours to complete the enrollment process. During the informed consent procedures, participants were asked to repeat the highlights of the study based on a standardized checklist of major study events (e.g. study expectations). Lastly, signed copies of the forms were given to each participant and informed of the dates and times of designated focus groups.

Moderators' training

Four certified HIV/STD prevention specialists (2 males, 2 females) from the local collaborating agency, of similar race/ethnicity as study participants, were recruited as moderators and trained for four hours. The training included, for example, discussions on pre- (e.g. moderators' roles) and post- (e.g. summary notes) focus group preparation strategies, moderating skills (e.g. facilitating), and promoting group dynamics (e.g. power sharing, diverse views), including the

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provision of relevant materials and resources, respectively. A week later, a mock focus group was conducted to re-enforce the knowledge gained, provide hands-on skills, identify and address concerns that may emerge, and re-enforce lessons learned.

Moderator guide

Same-sex focus groups regarding risky sexual behaviours have been successfully conducted, even among African American males, to inform programme development (Seal et al., 2003;de Visser, 2005). Based on discussions with youth and adult key informants, we developed a moderator guide to explore the determinants of risky sexual practices for this population. It consisted of open-ended questions eliciting responses for 'people their age' so they could speak freely without concerns about whether others in the group thought that those events were related to their own personal experiences. Lastly, the final moderator guide was pre-tested and further refined prior to administration.

Study participants

A convenience sample of 34 study participants was recruited, about five to six persons per focus group; of which, 74% (25) were eligible for participation. The participants completed the informed consents and were assigned to one of four focus groups; of which, 88% (22) participated. By centres, community centre one accounted for 27% (6) of the participants; community centre two, 23% (5); community centre three, 27% (6); and community centre four, 27% (6), respectively. Of the three no-shows, one was 19 and the others were 20 years old, and their sexual risk profiles were similar to study participants, except that all no-shows were from neighbourhoods associated with community centre three.

Focus group administration procedures

All moderators were African Americans between the ages of 37 to 43 years old. Two sessions were moderated by trained male facilitators and two by trained female facilitators. The focus groups were conducted in the offices of the community centres and the collaborating partner. Prior to each focus group, participants completed a sign-in log, eligibility re-confirmed, and were provided with first name only adhesive tags for identification purposes, and sat in circular or rectangle formats, where applicable. During focus groups, the purpose of the study was reiterated and confidentiality stressed. Ground rules were read and posted, and participants given the opportunity to amend those rules. Then, they were encouraged to actively participate in discussions, reassured that there was no right or wrong answers and were also provided with refreshments.

On average, a focus group lasted for about ninety minutes (range: 60–120 minutes). Afterward, each participant was given three condoms, $10 for participation and $5 for transportation reimbursement (total: $15). Lastly, the study protocols were approved by the Institutional Review Board (IRB) of the Pacific Institute for Research & Evaluation (PIRE) and clearances obtained from our partners.

Analysis of focus group data

Focus group data were analysed within the conceptual framework of qualitative research (Bloor et al., 2001;Krueger, 1998;Miles & Huberman, 1994;Strauss & Corbin, 1998;Krueger & Casey, 2000). Content analysis of the focus groups was based upon a thematic topic guide that covered three broad areas of young men's perceptions of sexuality and condom use. An open-ended questionnaire was used to guide the focus group discussions. Topical items addressed general sexual behaviour (e.g. how decisions to have sex are made), condom use behaviours (e.g. condom use skills), and substance use (e.g. role of alcohol and/or drug in condom use decisions).

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Focus group discussions were tape-recorded and transcribed. After being reviewed for accuracy, the focus group transcripts were read several times and interpretations discussed by the authors. Due to the small number of focus groups, transcript data were summarized and analysed manually according to thematic topics. The transcripts' textual units were organized by topical questions and prioritized according to views expressed by a majority of participants as well as those minority views that elicited animated discussions.

Results

I. General sexual behaviours

Participants across all groups admitted that the decision to have sex is made very early in relationships, most often by the time of the first date or even before. One participant described that 'Every day I come out the door waking up looking for women. I decide before I even wake up that I'm looking for some woman to be with.'

When asked how they would respond if sexual interest was not reciprocal, most participants explained that they would try a little harder to persuade the woman before seeking sex elsewhere. As described by one participant, opportunities for sex were too plentiful for rape, especially since sex could be purchased:

> Then you move on, you know, you know, like I really don't understand rape, you know what I mean, it's too much out here to rape anything. If you want to rape anything, go buy some pussy, you know what I mean, so that's what I'll say to it.

II. Condom use behaviours

General views—Most participants described the reasons for and benefits of condom use in terms of pregnancy and disease prevention. Additional pregnancy-related benefits included saving money by not having to pay for abortions, not getting 'trapped', and not invoking the anger of a sexual partner's parents because of an unintended pregnancy. One participant cited condom variety as a positive thing about condom use:

> … [B]eside the STDs and the baby factor, I like the fact that they make so many different types of condoms, that's a positive because it don't just put condoms in a box like you use this one and that's it. You can mix it up and get your partner involved in it – strawberry, banana, vanilla, thick, you know it'll give a variety to people who would be like 'I'm not using that because it's too thick,' they got the thin ones for you, or 'I'm not using it cause it don't got no ridge,' so they got the ridge one for you, you know how it is.

The issue of sexual safety was also a major theme among discussants. While some discussants believed that they could judge a potential partner's sexual health visually, others voiced fear of the unknown as a primary reason for condom use. One participant even believed that 'these days they got some diseases that eat through condoms … you got to be careful who you sleeping around with'. As described by a participant in another group, the major benefit of condom use was:

> Just being safe from people that I don't know. I don't know everybody's hygiene, how they wash their body and stuff like that and who they with, you know. People already know, you see AIDS commercials everywhere, condom commercials everywhere and they say half the population in the world is infected with AIDS.

Conflicting views—The issue of being able to visually determine a partner's sexual health occurred in all the groups. The following exchange in one discussion group illustrates the conflicting views held by participants:

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> It all depends on the female, if the female's bogus, I'm putting on a rubber you know what I'm saying, but if she's fine I ain't going to put on no rubber, playing it safe.

Also, another participated also stated:

> My thing is like people go off how they look. Okay, they say she look good, she ain't got nothing, so I'll go on and hit that, but you got to look at just because she look cute, you know, she might have a nice little ass and all, fine clothes, nice little lips on her, you can't always judge because the way she look, you know what I'm saying.

Also, reasons given for young men not using condoms included lack of interest in condom use, lack of immediate access to condoms, inconvenience, the mood-killing length of time it takes to put on a condom, and female partner's disinterest in condom use. By far, the largest rationale was general disinterest in condom use, which was often related to disliking the feel of condoms, not knowing how to use a condom properly, and not caring about the consequences of not using a condom. Getting caught up in the moment and not wanting to spoil the mood by taking the time to retrieve and put on a condom were also cited as reasons for not always using condoms.

> The most common thing that anybody would say about a condom and why they don't like it is that you can't feel it and it's true, you know what I mean, it takes away all the feeling, the wetness you know, the wall, the tightness, the rubber feels that.

Relationship dynamics—Most participants explained that condoms are usually used in new relationships. As described by a participant, 'Most condoms are used in new relationships, it's the long relationships you gotta worry about.' To this end, many respondents felt that condom use in a trusted or long-term relationship was not necessary because it could make one's sexual partners suspicious about sexual fidelity. Although several participants described the issue of male infidelity as a reason for using condoms with casual sex partners, only one participant suggested the use of condoms in a trusted relationship as a means of protecting men against their girlfriend's infidelity.

Many participants explained that the decision to discontinue condom use in serious relationships is based on the type and length of the relationship and HIV serostatus. The point in relationships where condom use is discontinued by mutual agreement usually occurs when the couple has been together for more than a few months, when both partners have been checked for HIV/STDs, or when the woman decides she wants to get pregnant. Several participants also described scenarios in which condom use was discontinued more by accident than by design.

> Me personally, me and my girl have been together like for six or seven months, so we use condoms every time, but the last month, I say two months, she's on birth controls so we haven't being [using condoms], its like it just happened, the next time it happened, then a couple of weeks ago we put a condom on and it didn't feel right.

Peer/partner communication—Several participants explained that they rarely talked about condom use with their male friends. One discussant explained that other than asking each other for *condoms* 'we don't basically sit around and just talk about condoms'. Other participants explained that conversations with their male friends revealed that many refused to wear condoms because 'they say it take[s] the fun of out it'. Participants revealed that condom talks with female sex partners were equally sparse and, if they occurred at all, usually took place immediately before or after sex.

Other participants expressed that discussions about condom use were unnecessary and that young men will either have condoms and use them, or will not have condoms and have sex anyway. Furthermore, in instances where women might not want their partners to use condoms,

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many participants conveyed that they would wear a condom anyway, whereas just as many conveyed that they would have sex without a condom.

Parental attitudes—Parental attitudes about condoms were also mentioned in terms of motivating condom use amongst this population.

> Condoms, it seem there's more of a negative light than a positive light. Like your momma catch you with a condom, you know your momma don't like that, or any parent doesn't like that, and say what you got a condom for, and you'll be like 'wouldn't you want me to have a condom rather than not have a condom?' I think it should be definitely more in a positive light than a negative light.

Condom availability—All of the participants stated that young men would be more inclined to use condoms if they were made more available. In particular, participants described several situations that discourage condom use such as the lack of physical and safe access to condoms, affordability, knowing and enjoying the feel of sex without a condom, condom breakage, and the belief that sexual health could be ascertained visually.

> Sometimes that's the only way a [brother] will use a rubber is if he's getting it free, because if a [brother's] got to come out of his pocket to get some rubbers for some coochie, they ain't going to go. That's just like you saying man, I'm [about] to take Chauka to the motel, I'm not [about] to take her to no motel, I got a big ass back seat or my man got a[n] empty crib, you know what I'm saying. I'm just keeping it real.

Brand name & size—As far as condom size and brand name, all participants agreed that both size and brand matter significantly. For most participants condom size was directly related to comfort, appropriate fit and potential for breakage. Similarly, condom brand was also related to potential for breakage, size, comfort of fit, and strength and durability of protection. Some participants believed that cost of condoms was also related to reliability of protection, with many naming Lifestyle condoms as a cheap brand that, although thinner than other brands, are prone to breakage, ill-fit, and being 'dried out'. Similarly, Magnum brand condoms were often cited for good fit, as were Trojans for their 'thick and sturdy' strength. As described by a discussant:

> I'm going to be honest, I mean, I know I'm probably a sucker for marketing, but just sometimes the name make it seem safe, you know, you talk about Magnum, that's a gun you know somebody protecting themself, you know Durex, it sounds like durable, Trojan you know a big army, so it kind of makes you feel a little bit safer just by the name. You think, lifestyle, the first thing that pops in my mind is alternative lifestyles.

Although most participants expressed that young men prefer free condoms, at least one participant qualified that 'It depends on the free condom'. All agreed, however, that they would be receptive to free name brand condoms.

Oral sex—None of the participants had used or heard of other men using condoms for oral sex. As described by a participant, '[I]t's called sucking dick, not sucking rubber … nine times out of ten, I know that none of my guys put on no rubber when they getting head.' Similarly, another participant explained, 'I can have a Kiss a Mint condom around and still not put it on,' a participant in a different group conveyed that 'I don't care what nobody says, when you put that Kiss a Mint on, I can't feel nothing but her pulling up on my thing'. Although only a discussant believed that condoms were not necessary for oral sex 'because you can't catch nothing', most participants believed that condom use interfered with physical sensations in oral sex.

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III. Substance use

All participants conveyed that alcohol and drugs played a large role in decisions about sex and condom use. The majority believed that alcohol affected condom use decisions more so than drugs, as one participant stated: 'You can just down a couple of forties and you got your girl and you know condom use is the last thing on your mind.' Participants across all groups expressed that if a woman didn't 'look dirty' and, often, even if her sexual history was questionable, alcohol use greatly decreased the likelihood of condom use: 'When you drunk or high it's just the spur of the moment, stuff just happens, you better hope the person you're with is clean.'

In addition, participants indicated that cocaine and crack inhibit sexual urges, heroin hinders erections, and that certain strains of marijuana could enhance sexual urges but not to the point of interfering with condom use decisions. As expressed by one participant, 'When you drunk you don't care, if you high you actually know what you're doing.' The drug ecstasy, however, was described by discussants as greatly increasing sexual desire. According to one participant: 'Now, X ain't nothing but a horny pill.

In terms of feeling that people get drunk or high when they are getting ready to have sex, participants expressed that alcohol just made it easier for both men and women to rationalize what they were planning to do anyway:

> See the whole drinking thing or smoking you know what I'm saying, it just helps your conversation, helps her even feel better about knowing what she know [she's going] to do anyway. She just want to use the liquor as an excuse to hit, and it go for the males too, like I really didn't want to do it, but the liquor is talking to me.

IV. Prevention programming

When asked about the likelihood of exposure to programmes encouraging young men their age to use condoms, members of the discussion group were divided. Although many participants felt that condom use *should* improve with the technical consequential knowledge gained from condom use programmes, others believed that such programmes would not make much of a difference to men already committed to non-condom use. As expressed by one participant, 'I know a couple of [brothers], Joe, that just don't care. They already know the consequences and repercussion behind what can happen to them, you know what I'm saying.'

When asked what could be done to encourage condom use among young men, discussants suggested commercials, graphic visuals of the consequences of unprotected sex, and easier and more affordable access to condoms.

> I was agreeing with what my man said. They showed us at school, but all I want to say is all you got to do is read, scare these [brothers] and show them, you know what I'm saying, that's the best thing to get a black male now days to get him to do something is to scare him. Scare him to the point that he's scared straight, get him to the point where he don't want to fuck up no more.

Conclusion

The analyses of the qualitative data revealed that significant myths and misconceptions exist regarding condom use. As such, there is need to promote condom knowledge. Nevertheless, simply providing condom-related knowledge may be inadequate because evidence clearly points to a lack of an association between condom knowledge and effective condom use skills (e.g. See de Visser, 2005;Kirby, 2001).

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Furthermore, the qualitative data also point to a need to incorporate condom-related protective factors into condom promotion programmes. Combined, these findings clearly support the need to adapt prevention programmes (e.g. See Stanton et al., 1996;Jemmott et al., 1998;St. Lawrence et al., 1995;Kirby, 2001;de Visser, 2005;DeLamater et al., 2000;Diclemente et al., 1996;Kalichman & Cherry, 1999) that particularly builds upon the unique psychosocial and environmental contexts of this population.

The results of the current study clearly document the attitudes, behaviours and perceptions of a culturally homogenous group of young men and further provide a critical starting point for the design of larger studies to address the health-related needs of similar populations.

Lastly, a few limitations exist. First, the sample size for the qualitative interview was relatively small. Second, with the HIV/AIDS and qualitative research-related experiences of the moderators, the moderators were provided with minimal training in focus group moderation. Despite those limitations and the similarities of our findings to other published reports (e.g. See de Visser, 2005;DeLamater et al., 2000;DiClemente et al., 1996), the qualitative study was relatively conducted within the appropriate framework of qualitative research methods. Accordingly, further studies may still be warranted to substantiate our findings.

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