

# Urban African-American Males' Perceptions of Condom Use, Gender and Power, and HIV/STD Prevention Program

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The overall goal of the research project was to develop, administer and assess a brief male-focused condom promotion program for inner-city young adult African-American males. To achieve that goal, we conducted a formative study consisting of both quantitative and qualitative research methods. For the qualitative component, which was guided by the relevant tenets of the social cognitive theory and the stages of change model, a series of focus group discussions was conducted among the target population based upon a thematic topic guide that covered three broad areas: young men's perceptions of condom use relative to pregnancy and HIV/sexually transmitted disease (STD) prevention, gender-based issues surrounding condom use, and potential guidelines for the development of customized condom promotion programs. Those focus group discussions were audiotaped and the transcribed data summarized and analyzed based on those thematic topics. The findings revealed that respondents were more likely to assume that they know the risk behaviors of their sexual partners, more likely to consider pregnancy as a socially desirable outcome, more likely to control condom use within relationship dynamics and sexual contexts, and also more likely to provide suggestions on suitable components for program development. The implications and limitations of those findings from this qualitative component of the project are herein described, including potential recommendations for program development.

**Key words:** condoms ■ African Americans ■ men's health ■ gender ■ qualitative research & analysis ■ HIV/AIDS ■ health promotion ■ sexually transmitted diseases

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## INTRODUCTION

Young people are at increased risk for HIV/STDs and undesired pregnancies. Despite being unprepared to deal with the consequences of sexual activities, they continue to become sexually experienced at an early age.<sup>1,2</sup> In addition, young adults ages 18–25 years account for the highest rates of STDs among all age groups, especially so for African Americans.<sup>3–5</sup> Although newly diagnosed AIDS cases are declining, a comparable decline has not been observed among young adults,<sup>6</sup> especially those between the ages of 18–25 years. Moreover, based on findings from the National Survey of Adolescents and Young Adults, a survey based on a nationally representative samples of nearly 1,800 youth, 37% of young people between the ages of 15–17 years have had sexual intercourse, 36% engaged in oral sex, 39% have had 2–5 sexual partners, 86% were concerned about sexual health issues (HIV/STDs) and 51% had engaged in risky sexual behaviors after alcohol or drug use.<sup>7,8</sup> These findings were significantly higher for African-American males.<sup>7,8</sup>

Based on the summary finding of the 2001 Youth Risk Behavioral Surveillance System (YRBSS), another national, school-based self-reported survey of a representative sample of 9th–12th graders, 46% of youth (i.e., those aged 10–24 years) have had sexual intercourse, 14% have had ≥4 sexual partners, 33% had engaged in sexual encounters during the past three months, 42% did not use a condom during their last sexual encounters and 82% did not use any form of birth control method.<sup>4</sup> Moreover, the majority of adolescents are sexually experienced by age 19,<sup>2</sup> an indication that sexual activity may have occurred several years earlier, possibly during middle-school years. Subsequently, 9% of all high-school students reported being sexually experienced before aged 13, and one-third of 15-year-old boys and 21% of 15-year-old girls are sexually experienced, with a mean age of 16 years at first intercourse.<sup>2</sup> The risk-seeking behaviors of young minority males, particularly their failure to engage in self-protective sexual behaviors such as correct and consistent condom use, place them at high risk for HIV/STDs and undesired pregnan-

cies,<sup>2</sup> especially for African-American males.<sup>7,8</sup> This is of concern because of the adverse impact on their quality of life, the potential for contracting and transmitting HIV/STDs, as well as undesired pregnancies, and the health and economic impacts to society. Accordingly, as a research call to action to explore such public health concerns, this study was basically designed to identify the barriers and facilitators for correct and consistent condom use among young adult inner-city (or urban) African-American males.

## Theoretical Foundation

This study was based on two commonly employed program theories in behavioral-based prevention and intervention research to promote condom use: Bandura's social cognitive theory (SCT)<sup>9</sup> and Prochaska and colleagues' transtheoretical model (TTM)<sup>10</sup> or the stages-of-change model (SCM). Both theories have been previously used in HIV/AIDS prevention research, including condom use.<sup>11,12</sup> Basically, two essential behavioral determinants of the SCT are outcome expectancies and self-efficacy.<sup>9</sup> Outcome expectancies, for example, relate to the extent to which a person values the expected outcome of a specific behavior (e.g., condom use) based on the perceived reward or cost (e.g., prevention of HIV/STDs). Self-efficacy, in addition, is the belief that a person is capable of performing a particular behavior (e.g., effective condom use), even if it involves numerous challenges (e.g., condom slippage) that could be developed or enhanced through modeling and skill building (e.g., role plays). The SCM, on the other hand, particularly aims to change an individual's sexual behavior.<sup>10</sup> When applied to condom use behaviors, it consists of six stages: 1) precontemplation (e.g., no consideration for condom use); 2) contemplation (e.g., recognize the need for condom use); 3) preparation (e.g., think about condom use); 4) action [e.g., consistent condom use for shorter duration (<6 months)]; 5) maintenance [e.g., consistent condom use for longer duration (>6 months)]; and 6) relapse (e.g., experience barriers to condom use such as slippage). When collectively applied to sexual behaviors, both theories hypothesize that behaviors such as preventing HIV/STDs can be supported by an understanding of what must be done to avoid HIV/STDs (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.<sup>11,12</sup>

## Study Goal

The primary goal of the overall project was to develop a brief male-focused condom promotion program for urban young-adult African-American males. As such, a formative phase, guided by both qualitative and quantitative research methods, was initially conducted to bet-

ter explore the condom-seeking behaviors of the target population. The aim of the quantitative component was to implement and assess the program's feasibility of administration, as well as its short-term benefit in promoting condom use among urban young-adult African-American males. The preliminary findings from the quantitative component of this research study have been published elsewhere.<sup>13</sup> Specifically, the aim of the qualitative component was to identify and explore condom use barriers and facilitators based on the integration of both theoretical models in order to guide the development of a condom promotion program to be administered during project implementation. For this paper, we report the preliminary findings from the qualitative component of this project.

## STUDY METHODS

### Eligibility Criteria

Urban (or inner-city) African-American health-seeking males between the ages of 18–24 years who primarily access health services from one of four designated community centers in the project setting were recruited for participation into this research study. Furthermore, to be eligible for recruitment, a potential participant had to also be at high risk for HIV/STDs, such as evidence of HIV/STDs or self-report of unprotected sexual intercourse, inconsistent condom use or multiple noncommitted sexual partners in the past 3–6 months. Also, active informed consents and three recent verifiable locators or tracking information was obtained from all enrolled participants. Lastly, a participant was considered to be eligible if he understood English at the sixth-grade reading level.

### Enrollment Procedures

Eligible African-American males, for inclusion into the research study, were commonly recruited from non-traditional hang-out spots such as grocery stores, street corners or game centers in the surrounding neighborhoods of four designated community centers within the project setting. To ensure that we reach a diverse group of high-risk African-American males, the study also used a mobile van equipped with a television set showing musical videos, a sound system playing rap music and a loud public speaker system with a conductor rhyiming on the initiation and implementation of various community-focused HIV/STD prevention initiatives, including this project. During these recruitment drives, commonly used condoms within the African-American communities were also distributed onsite to interested community members, including eligible and ineligible study participants. Specifically, the study recruitment team approached individuals at those nontraditional spots, including passers-by and onlookers, about the goals of the condom promotion project and vice versa.

For those individuals who had shown interest to par-

ticipate in the research study, appropriate venues were secured to ensure privacy, as well as to determine their eligibility for enrollment into the study based on a standardized form that was developed to collect basic information such as age, community of residence and evidence of HIV-/STD-related risk behaviors. For participants meeting the eligibility criteria, and also for those participants required to provide additional information in order to confirm their eligibility status for enrollment purposes, locators and tracking information such as personal cell phone and pager numbers, contact information of close relatives and information on frequently visited hang-out spots were obtained. Also, conclusions were reached on a mutually acceptable time to meet within the next 24–48 hours in order to reconfirm their eligibility for enrollment and then administer the informed consent procedures, where participants were asked to repeat the highlights of the informed consents based on a standardized checklist of major study events, including perceived benefits (if any), the expectations established by the study team and enablers for enrolled participants, respectively. Lastly, signed copies of the informed consent forms were provided and participants informed of the date and time of their scheduled focus groups.

### Moderators' Training

Two male and two female African-American certified HIV/STD prevention specialists from the local collaborating agency were recruited as focus group moderators. Those four experienced moderators were also trained for about four hours by an experienced university-affiliated qualitative researcher. The training workshop included, for example, discussions on pre- (e.g., preparation of venues, moderators' roles and budgeting time, etc.) and postsession (e.g., incentives, moderator summary, completion of forms, etc.) focus group administration strategies; moderating skills (e.g., welcoming statement, overview, ground rules, asking questions, etc.); and promoting group dynamics during focus group administration (e.g., power sharing, diversity of views, etc.), including the distribution of relevant handout materials and resources on focus group administration, respectively. A week later, a mock (dry run) focus group discussion session was conducted in order to re-enforce the knowledge gained from the qualitative research training session and provide hands-on experience and address concerns prior to the implementation of the focus group discussions for the recruited study participants.

### Moderator Guide

Evidence suggests that gender-specific focus group discussions on risky sexual behaviors have been successfully conducted, even among health-seeking African-American males, to inform program development.<sup>14-17</sup> Based on insights from our local collaborating organization, selected adult key informants and representa-

tives of the target population, we developed and further refined a moderator guide to identify and explore the determinants of risky sexual practices, condom use barriers and facilitators, gender-related perceptions of condom use and the condom-based programming needs of urban young-adult African-American males. The focus group moderator guide consisted of open-ended questions that elicited responses for "people their age" so they could speak freely without concern for whether others in the group thought that those events were related to their own psychosocial and behavioral experiences. Lastly, the final moderator guide was pretested among a sample of the study population and refined prior to its implementation.

### Study Participants

Thirty-four urban African-American males between the ages of 18–24 years were conveniently recruited from nontraditional settings bordering four community centers in order to participate in four focus groups. Considering attrition, on average about 8–9 eligible participants per designated community center were recruited and subsequently enrolled per focus group. Of those participants, 74% (25) were eligible to participate in the study while 26% (nine) were ineligible for participation. Of the ineligible participants, eight did not meet the eligibility criteria because they were older (25–44 years) to be enrolled into the study, while the remaining ineligible participant was younger (16 years) than the required age for recruitment purposes.

The 25 eligible participants showed interest in the study, completed the informed consent procedures and were subsequently enrolled into the research study. Based on mutually acceptable agreements, the enrolled participants were assigned to one of four designated focus groups. Of the 25 enrolled participants, 88% (22) participated in their assigned focus groups, while the remaining 12% (three) did not show up on their assigned dates for participation in the focus group discussions. Of the 22 African-American males who participated in the four focus group discussion sessions, 50% (11) of them were 18 years old, while 18% (four) were 24 years old, respectively. The first focus group discussion session for community center 1 accounted for 27% (six) of those participants, the second had 23% (five) of participants for community center 2, the third had 27% (six) of participants for community center 3, and the fourth also had 27% (six) of participants for community center 4, respectively. Of the three enrolled but no-show participants, one participant was 19 years old, while the other two participants were 20 years old. The no-show participants had similar risk profiles, like other study participants, except that all of them were from the neighborhoods affiliated with community center 3.

## Focus Group Administration Procedures

Four focus group discussion sessions, designated as one focus group per community center, were conducted to identify the barriers and facilitators of condom use among the enrolled study participants. Of those focus groups, two group sessions were moderated by trained male facilitators, while the two remaining group sessions were also moderated by trained female facilitators. All moderators were African Americans ages 37–43 years old. The focus groups were conducted in designated office spaces at the respective community centers, except for the second focus group (for community center 2), which had to be relocated to the office of the collaborating organization.

On the day of each focus group administration, enrolled participants had to complete the sign-in log and their eligibility (e.g., consent form) for participation in assigned focus groups reconfirmed. First-name-only adhesive tags were prepared and provided to each participant and instructed to sit in a circular or rectangle format, as required. During each focus group session, the purpose of the focus group was reiterated and confidentiality stressed. Participants were then asked to freely speak up if they had questions or concerns that needed to be clarified and/or addressed, and then the focus group ground rules were read and visibly posted in the room. Also, participants were asked to amend or enhance the ground rules to encourage participation. Participants were encouraged to actively participate in discussions and reassured that there were no right or wrong answers (or responses) to the open-ended inquiries. Also, refreshments were provided during each focus group discussion session.

On average, focus groups lasted for about 90 minutes, ranging from a minimum duration of one hour for the first focus group discussion session to a maximum duration of slightly over two hours for the last focus group discussion session, respectively. English was the medium of communication. At the end of each focus group administration, participants were provided condoms (or instructed to take a few condoms from the conference table) and then asked to sign a standardized form (e.g., name, date, condom taken or not, incentive provided or not, reimbursed for transport cost or not, etc.) prior to obtaining their incentives. Each enrolled participant who completed a focus group received \$10 for their time and effort and \$5 as reimbursement for transportation cost, equating to a total of \$15. Lastly, the study protocols and implementation procedures were approved by the institutional review board of the Pacific Institute of Research & Evaluation regarding the protection of human subjects prior to the commencement of this research study, including the appropriate clearances from collaborating and participating organizations.

## Analysis of Focus Group Data

Focus group data were analyzed within the conceptual framework of qualitative research.<sup>18-21</sup> Content analysis of the focus group discussions was based upon a thematic topic guide that covered three broad areas of young men's perceptions of condom use related to pregnancy (e.g., Do young men your age want to have children?) and HIV/STD prevention (e.g., Do you think that there are people out there that want to use condoms but just don't use them for some particular reason?), gender-based issues around condom use (What do young men your age think the role of the female is in using condoms?), and guidelines for effective condom use promotion programs (e.g., What would you like to see in a program to promote condom use among young people like yourself?). An open-ended questionnaire was used to guide the focus group discussions.

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 authors. Due to the small number of focus groups, transcript data were summarized and analyzed 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 minority views that elicited animated discussion.

## STUDY RESULTS

### Pregnancy, HIV/STDs and Condoms

Responses varied when participants were asked if they were more worried about pregnancy or HIV/STDs. Whereas many respondents admitted that pregnancy was not a financially feasible alternative at this time in their lives, several respondents shared that they were already fathers, while other respondents viewed having children as a socially desirable outcome, especially in relation to the uncertainty of life. As described by one respondent, "Some people just want a kid because they feel how long they got to live on this earth." Other respondents indicated that while they may be concerned with thoughts of pregnancy or HIV/STDs, those thoughts disappeared when faced with an opportunity for a sexual encounter, such as for the participant that explained, "This is like my fourth [HIV] test, you know what I'm saying, and every time I take one I'm thinking about it, but once that woman's in my face, I'm not even studying it." A respondent in a different group described four possible scenarios around young men's thoughts about having children:

*I think you'll have to ask that young man depending on what's going on in his life right now. He might be with some chick who got his mind gone. She might have him all way messed up so they using rubbers, and females do this too, all of a*

*sudden he takes it off to try to knock her up and get her pregnant and trap her. Then you got the cat like me that's like, 'man I got two jobs and go to school, I can't have no kids.' Then you got the other cat that's like, 'man I ain't got no job and I don't go to school, I can't have no kids.' Then you got the cat, 'I ain't got no job and I don't go to school, I try to get her pregnant and she going to take care of me and my baby,' you know what I mean?*

## Gender-Based Issues

All participants felt that decisions about condom use belonged primarily to males. Although a few participants conceded that women might have a "small role" in such decisions, ultimately, the male, as "boss" or the person "in control" of the relationship, exercised "more power or advantage over the female" and, as such, had a certain amount of responsibility for protecting both himself and his sex partner. While most participants claimed that they would still use a condom even if their partner insisted that they not, many participants explained that their decision to not use a condom would depend on the nature of their relationship with the woman, e.g., "[Such a request has] got to be coming from my baby momma or one of my girls."

Although participants in all groups had heard of the female condom and most had seen one, only a few participants had ever used one. One participant felt that female condoms used in conjunction with male condoms were "a double negative" as far as sensation impediment was concerned. Other participants felt that female condoms were good alternatives to having no condoms.

## HIV/STD Prevention Program

Although a few participants had attended community- or prison-sponsored HIV/STD prevention programs in the past, the majority of participants' exposure to such programs was limited to school-based sex education programs or none at all. Those who had attended such programs found them to be useful in terms of learning about various diseases and how they were contracted and about the technical aspects of using a condom. In terms of what they would like to see in such a program, participants described interest in learning how to put on and properly use a condom, free condoms, rappers and billboards promoting condom use, female facilitators of such programs, "more tapes of what would happen if you used condoms or what would happen if you don't," as well as learning about various diseases and how they look, how they are spread and how to tell if one might be infected. Additionally, participants wanted to see some type of remuneration, either monetary or free food, condoms and/or pamphlets. As explained by one participant:

*A lot of young black males ain't going to do nothing, they trying to get a dollar in their pocket or they trying to see something as if it's worth doing, you know what I'm saying, they not going to do it unless they going to get paid.*

Most participants felt that the location of such a program would not matter, although one participant did express that programs should be held within walking distance so that transportation would not be an issue for people without cars. Similarly, another participant explained that clinics might not be the best setting for such a program because "some people would probably be embarrassed to even go to a clinic; they probably think somebody might think they got something. They see them walking into a school, nobody would care about that."

As far as the age, ethnicity and gender of facilitators of such a program, some participants felt that opposite-sex facilitators might work best at drawing in participants, whereas others believed mixed-gender or same-gender facilitators could relate more to a group of young males without distracting their attention from the message. Similarly, some participants felt that facilitators' age mattered less than their attitude and ability to relate to participants, while others expressed doubts about being able to speak openly to elders without being seen as disrespectful. Along those lines, participants explained that facilitators should be of the same ethnicity as participants:

*About the race thing, say it's a white man in front of us talking, it's a Puerto-Rican guy in front of us talking, he don't know how we feel as a black people, he don't know how we get down, because he's not in our predicament, he don't know how we live or how we do what we do because he's white, he got his own perspective of how he do things so I feel it does matter because a white man don't know what we go through.*

*Yes, because you don't want no white person coming in here to talk to a bunch of people in the hood, you know what I'm saying, they can't relate to what we're talking about. They don't know really what we've even been through or what we're going through, I mean you know we want someone with our own values and fears.*

Focus group participants believed that a condom use program should be no longer than 1–2 hours, preferably less, and that the presentation should be interactive in order to maintain participants' interest. The majority of participants also felt that such a program should be administered in a group setting in order to generate different opinions and facilitate discussion.

Suggested names for a condom awareness project

amongst African-American young males were described in terms of safety and mortality (Operation Stay Alive; Operation Stay Safe), sex and slang for sex (Banging Safety Project, Safe Busting Down), and visual graphics (e.g., a baby with a warning sign). Respondents also implied that the name of such a project needs to be short and catchy, and make reference to ethnicity:

*Something like the word BLACK, each letter would stand for something because really this is HIV/AIDS. HIV/AIDS affects us the most, you feel me, black males and females 13 to 24, we're catching it faster than anybody, so I think the title should have something to do with the community.*

*You definitely want to use "sex." That will catch their eye twice.*

*"Togetherness," because we're it together, we're having sex with girls and they having sex with us you understand, so that would affect us together.*

*"Strong Arms" because "strong" is a very versatile word, meaning so many things like we're strong as a group, we're strong as one person, I mean we're like a chain, right—one link go bad, we all bad, so we're strong, so we are all strong, so we bring that unity together, Strong Arms.*

*I think the project name should be "The One and Only True Love, Condoms." You know, condoms will save your life, you won't catch nothing so you won't have no baby, stuff like that.*

## DISCUSSION

Several factors relevant to the development of HIV-/STD-related prevention programs, including condom promotion programs, for such high-risk urban populations like African-American males, were retrieved from the analyses of the data. First, while several study participants were already fathers and did not consider pregnancy to be a financially feasible option, they still viewed having children to be a socially desirable outcome. Such findings have negative implications for the promotion of condom use, especially within the contexts of relationship dynamics perceived as being stable. Further, the perception by respondents that they were reportedly knowledgeable about their sexual partners' perceived risk behaviors, as well as determining a casual sexual partner's perceived HIV-/STD-related risk behaviors based on the person's social interactions and networks, raises significant public health concerns. As such, there is a need to continually support, promote and sustain culturally relevant condom-related knowledge among this population in order to debunk such myths and misconceptions about HIV/STD prevention.

Second, the data also revealed that urban African-American males continue to control and dominate decisions regarding condom use, including other contraceptive methods, in sexual relationships. For example, there was consensus among respondents that decisions about condom use primarily belong to males, who were considered to be the "boss" or "person in charge," with females being perceived as only playing very minor roles in such situations. And if a female sexual partner, for example, made a request for condom use during sexual encounters, such a request could only be taken into consideration if it had originated from the male's perceived stable partner or child's mother. Regarding female condom, study participants were more likely to have heard about it, less likely to have been knowledgeable about it, less likely to have used it and even more likely to exhibit unfavorable attitudes about it. This suggests that condom promotion programs should incorporate information on various forms of contraceptive methods, including female condoms, as well as information on gender roles, sexual and relationship dynamics, pregnancy and child-bearing, and behavioral skills such as partner communication or negotiation within the contexts of HIV/STD prevention.

Third, there is a scarcity of community-level HIV/STD prevention programs, including condom promotion programs, that target high-risk male populations who reside in disease-burden inner-city neighborhoods and communities. The good news, however, is that most participants were aware of and/or had participated in school-based HIV/STD prevention programs. With an increased likelihood that such populations will drop out of school and further engage in high-risk sexual behaviors, such findings present a remarkable opportunity for traditional research-driven institutions to collaborate with community-based organizations in order to support, promote and sustain community-level HIV/STD prevention program at nontraditional settings, as well as to deliver HIV/STD prevention messages to such hidden urban male populations who generally do not receive and/or participate in HIV/STD prevention programs.

Fourth, HIV-/STD-related prevention factors relevant to the development and implementation of condom promotion programs were successfully advanced during focus group discussions. For example, participants had considered several factors to be useful for program development, such as: promote condom use skills such as condom insertion, condom knowledge and condom use self-efficacy; provide free condoms and make them available at nontraditional community settings; incorporate and utilize rap stars to re-enforce condom promotion messages; use small-group settings with facilitators of similar racial/ethnic identities to disseminate condom promotion messages, preferably female facilitators in order to motivate males to participate; promote and support interactive prevention programming in order to maintain participant's interest; restrict program administration to <2

hours; administer programs within short commute (program venue); recruit facilitators with the right attitudes and abilities to relate to such populations and that the age of facilitators was not an important consideration for program administration; provide some forms of enablers to promote recruitment and participation; administer such programs at nonclinic-based venues in order to prevent perceived stigma; and support a project name that, in reality, positively reflects the racial/ethnic contexts of the target population. Finally, the suggestions advanced by those urban young-adult African-American males clearly pointed to the need for a culturally relevant, yet multifaceted approach to promote, support, maintain and sustain condom use among this population.

In summary, although focus group data may be limited in their applicability to a general population, focus groups have a unique advantage of representing social interaction among discussants and thus can provide insight into a group's shared understanding of everyday life.<sup>22</sup> Additionally, strong opinions within a focus group interview can stimulate the disagreement, qualification and/or defense of stated opinions among discussants. This process of censorship, argumentation, vying for superiority of opinions and expression of contrary views facilitates the emergence of socially acceptable and prevalent opinions and replicates how opinions are formed and altered within the familiar context of a group discussion.<sup>23</sup> The results of the current study reveal the attitudes, behaviors and perceptions of a culturally homogeneous group of young men and can provide a critical starting point for the design of larger studies that address the health-related needs of similar populations.

Lastly, one of the limitations of this study was that the sample size for the qualitative interview may have been relatively small. Nevertheless, as one of its potential strengths, this study was appropriately conducted within the appropriate framework of qualitative research methods. Accordingly, further studies may still be warranted to substantiate our findings.

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