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Context of First Same-Sex Condom Use and Nonuse in Young Black Gay and Bisexual Males

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Abstract

Despite high HIV rates among young Black men who have sex with men (YBMSM), there is limited data about condom use during first same-sex (FSS). This study sought to understand socio-contextual factors of 50 YBMSM age 15–19 that influenced condom use during FSS. Condom use was influenced by individual, partner and community factors. Individual factors: recent illness or STI promoted use, while frequent HIV testing prompted nonuse. Partner factors: partner's proactively encouraging condoms, while trust and condom discomfort promoted nonuse. Larger community factors - presence of females were key for use, while limited sexual health information combined with peers who discouraged condoms prompted nonuse. A multi-level approach may be useful in developing sexual health programming for these young men.

MeSH Keywords

Adolescents; Black Men Who Have Sex with Men; First Sex; Condoms

Young Black men who have sex with men (YBMSM) living in the United States (U.S.) acquire HIV at a rate 3 times higher than their white male counterparts (Koblin et al., 2013), despite reporting comparable rates of condomless anal intercourse, substance use, and number of sex partners with unknown HIV serostatus (Millett, Peterson, Flores, Hart, Wilson et al., 2012). Stall et al. (2009) suggests that given the high HIV incidence and prevalence rates in YBMSM, approximately 60% of uninfected 18 year-old YBMSM living in the U.S. will become HIV positive by the age of 40. We know very little about first few same-sex sexual experiences of YBMSM and whether these early experiences may be a sentinel event in risk for HIV exposure.

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Condom use during first same-sex is likely influenced by multiple factors at varying levels of individuals' social-ecology: individual, partner, and community levels, consistent with a socioecological framework (Bronfenbrenner, 1992). One explanation for higher rates of HIV in YBMSM may be the composition of YBMSM sexual networks that may have higher background HIV prevalence, which may inadvertently expose young men to sex with an HIV positive partner (Rosenberg, Millett, Sullivan, del Rio, & Curran, 2014; Stall et al., 2009). Others have suggested that partner dynamics during penetrative sex including partner's masculinity and inability to negotiate condom use in the receptive sexual position (Fields et al., 2012), and partner's older age and sexual experience that dictate condom use during first sex (Arrington-Sanders et al., 2015) may predispose young men to HIV. Most of this work has failed to specifically examine sexual behavior during first sex and the context of condom use during these first experiences. Attempts to understand the context surrounding first same-sex in YBMSM are crucial to meet public health goals centered on promoting healthy sexuality and prevention of sexually transmitted infections (STIs) and HIV in YMSM because such early experiences appear to promote subsequent adult sexual health behaviors, including condom use in YMSM and adolescents more generally (Shafii, Stovel, Davis, & Holmes, 2004; Bauermeister, Leslie-Santana, Johns, Pingel, & Eisenberg, 2011).

At the individual level, prior work focused on first same-sex sexual experiences in young men suggests that YBMSM have a higher odds of early sexual debut compared to other YMSM, and that early sexual debut is a predictor of poor rates of condom use during first sex and future risk behaviors (Outlaw et al., 2011). Condom use during first same-sex in YBMSM may be complicated by concepts of adolescent identity and sexuality development as well as relationship expectations (Bauermeister et al., 2011; Savin-Williams, 2009). Recent studies examining early male partnerships in YMSM have found that 40% of YMSM, including YBMSM, engaged in condomless receptive/insertive sex with their first few male partners (Glick & Golden, 2013). Condom nonuse in YBMSM may be further influenced by factors such as internalized homonegativity, perceptions of stigma toward homosexuality (Waldo, McFarland, Katz, MacKellar, & Valleroy, 2000; Torres et al., 2013) and experiences of social isolation due to a lack of social support during sexual exploration (Arrington-Sanders et al., 2015). Such isolation can predispose some youth to rely on non-traditional resources to find information about engaging in sexual behavior with other men (Arrington-Sanders et al., 2015) and act as a mechanism to cope with stress caused by intolerance and stigma related to same-sex behavior from the community (Preston, D'augelli, Kassab, & Starks, 2007). YBMSM may also have higher levels of homonegativity given the intersection of race and sexual identity, and these intersecting identities may impact experiences and reveal socio-cultural factors that impact risk for HIV (Bowleg, 2013). In fact, it may be as YBMSM experience a greater awareness of racism, homophobia and heterosexism during sexual development, they may engage in behaviors such as inconsistent condom use with partners that may contribute to health disparities in YBMSM (Bruce, Harper, & Adolescent Medicine Trials Network for HIV/AIDS Interventions, 2011).

Previous work, focused predominantly on heterosexual adolescents, has shown that many first sexual experiences occur without condoms (Khurana & Cooksey, 2012). Younger adolescents are more likely to report inconsistent condom use or nonuse during first few

sexual relationships (Williams & Fortenberry, 2011), with condom use predicted by proximal factors (alcohol use, relationship type) and distal factors (family class, race) (Sprecher, 2013). Condom nonuse has also been associated with older partner age, low self-esteem, and low condom self-efficacy (Williams & Fortenberry, 2011; Sprecher, 2013). In contrast, condom use at first sex has been associated with positive communication regarding condoms, parental influence, and care-seeking behavior (Stone & Ingham, 2002).

Sexual networks of YBMSM that have persistently high rates of HIV (Millett, Peterson, Flores, Hart, Jeffries et al., 2012; Stall et al., 2009) make condom use during first same-sex especially important. Understanding the socio-contextual factors that act as a barrier or a facilitator to condom use during first same-sex sexual experiences may be crucial to averting new HIV infections in YBMSM. In this study, we sought to understand the contextual factors that may influence condom use described by YBMSM during first same-sex.

Method

Participants

We recruited a community-based sample of 50 Black gay and bisexual birth-assigned male adolescents to complete a 10-minute Audio Computer Assisted Survey Interview (ACASI) and an in-depth qualitative interview about consensual first same-sex sexual experience. Experiences of child sexual abuse were not included in the interview. Participants were between the ages of 15 and 19 years old. The lower age boundary of 15 years was chosen based on research that first same-sex sexual debut occurs around 15.5 years (oral sex) and 17.2 years (receptive and insertive anal sex) (Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010). Participants' self-reported racial identity included African-American, Black-Caribbean, Black-Arab, and Black-White.

Sampling

Participants were recruited using multiple recruitment methods including snowball sampling, community-based and venue outreach at local gay, lesbian, bisexual and transgender (LGBT) organizations, clinics (STI, adolescent, and school-based health) and social media where a study profile describing the study was created (Facebook, Jack'd). Participants who were 17 years-old were recruited if they were seeking clinical services related to reproductive, sexually transmitted infections, sexuality care in the clinic and at local community organizations or community-based and venue outreach. The majority of the sample was recruited through snowball sampling (42%, N=21, Table 1). Consented participants were given six study referral cards to invite social (or sexual) contacts to participate, and were provided \$10 remuneration for each eligible referral. Most participants referred 0–2 contacts.

The Johns Hopkins School of Medicine Institutional Review Board approved this study (NA_00074044#) and its contents including a parental waiver and written informed consent. Youth (<18 years) were allowed to consent for participation if they were seeking confidential reproductive health services covered under state Law, including sexual health information,

STI screening, and or HIV counseling and testing. A certificate of confidentiality was also obtained.

Procedure

Eligible and consented participants completed a 10-minute ACASI to collect demographic, relationship, sexual, and risk history data followed by an audio-recorded confidential in-depth qualitative interview ranging from 90–120 minutes in duration. ACASI items were derived from prior studies assessing STI and HIV risk in adolescent males in same-sex sexual experiences (Maulsby, Sifakis, German, Flynn, & Holtgrave, 2012; German et al., 2011). Participants received remuneration of \$40, and were provided refreshments and bus tokens for transportation. Unique identifiers were used during the interview and pseudonyms replaced names and places to ensure participant confidentiality.

The in-depth qualitative interview was conducted by trained, race-matched interviewers (authors 1, 2 & 5) in private areas such as an office or closed community space (community center or library). Experts (authors 1, 7) in the sexual development of sexual minority youth and researchers working with YBMSM helped to develop an in-depth qualitative interview guide grounded in phenomenological and constructivist frameworks historically used to uncover hidden meaning through deep reflection and description, rather than through explanations (Schutz, 1970). This guide focused on the participant's first romantic relationships and sexual experiences with other males and provided a general structure for discussion. However participants were able to provide their own definitions of sex based on life experiences and perceptions. Participants were also asked to describe any barrier protection (condom or dental dam use) during first same-sex sexual experience, including which factors promoted or inhibited condom use (Table 2).

Qualitative Analysis

All interviews were transcribed verbatim by an outside professional transcription company, and uploaded into qualitative analysis software (NVivo 10, Version 10; QSR International, 2012) to facilitate coding and analysis. The fourth author independently evaluated initial transcripts (N=10) to identify and collapse transcribed data into possible codes for the overall development of a coding schema; the coding schema was then presented and discussed by authors 1–5. The fifth author then applied the coding schema to the same ten transcripts evaluated by the fourth author to validate codes and collapse and or suggest new codes. After this second review of transcribed interviews, codes and emergent themes were discussed by all authors, with coding disagreements discussed and recoded as needed. To ensure agreement among codes and themes, 20% of all 50 transcripts were double-coded by the second author reaching high inter-rater reliability (Cohen's Kappa = .91) (Hruschka et al., 2004). In order to understand how condom use experiences were modified by personal, partner or larger socio-contextual factors, we organized codes and themes to reflect the young men's social ecologies (Bronfenbrenner, 1989). We examined participant's description of first same-sex experience with and without a condom using a contextual strategy that explored thoughts, feelings and events surrounding the experience. This approach was used to examine adolescents' responses within the interpersonal and social context of the experience.

We further conducted two validation checks using a member check-in to ensure quality and credibility of the emergent themes (Guba & Lincoln, 1981). We used a focus group format to conduct the member check-in. Each group consisted of five gay or bisexually identified Black men aged 19–23. This age range was chosen because of its proximity to the age of the participants in this study and the ability for young men to compare their own experiences of condom use during first sex with a male partner. Participants of the member check-in were presented themes that had emerged from participant interviews and allowed to discuss whether their personal experiences were consistent with the phenomena described by interview participations. Two-member check-ins were conducted after the first five and twenty-five interviews were complete. Member check-in participants were recruited from partnering adolescent health clinics, community-based organizations and social media sites (Facebook, Adam4Adam, Jack'd). We separately presented themes to a community advisory group of clinicians, researchers and youth prevention program specialists from the lesbian, gay, bisexual and transgender community to independently verify themes that emerged from the qualitative analyses (Lincoln & Guba, 1985). All community experts had extensive experience working with the YBMSM.

Results

Selected characteristics of the sample are depicted in Table 1. The mean age at time of interview was 17.6 (SD=1.3) and reported a mean number of lifetime sex partners of 13.3 (SD=14.5) with a median of 8.5 partners (25th percentile = 4 partners). Lifetime number of sex partners included numbers of both male and female partners and all types of sexual experiences (oral, anal, vaginal). Most (96%) self-identified as “African-American” during baseline ACASI, but five participants qualitatively described themselves as Black and identified as: Black-Arab, Black-Caribbean, or Black-Latino. Most participants (62%) self-identified either as gay or homosexual or bisexual 34% (n=17). Two participants were categorized as other (4% or n=2). This was inclusive of one heterosexually identified youth. The mean age at first same-sex experience was 13.9 years (SD=2.6) and the mean age of partner at time of first experience was 16.6 years (SD=5.5). Only five participants reported having a partner 5 years older during first sex. We found no differences in themes by partner age or sexual orientation except that youth who identified as bisexual more often described condom nonuse that occurred in the context of substance use (alcohol and marijuana use). The majority of participants characterized their first partner as a friend (63%), with fewer participants reporting first partners that were new acquaintances (20%).

Most participants (62%, N=31, Table 1) described that their first same-sex experience involved both oral-penile and penile-anal sex, with the next most common first sexual experience being oral-penile only (30%, N=15, Table 1). Only 4 participants (8.9%) reported using condoms during first oral-penile sex. Among participants who reported penile-anal sex, the majority (77.2%, N=27) described being the receptive partner and over half (54.3%, N=19) reported using condoms during this experience. Very few participants (N=5, 10%) recounted that their first same-sex experience involved oral-anal intercourse and none described using a barrier method during oral-anal sex.

Multiple themes emerged across participant interviews related to anal-penile and oral-penile condom use and nonuse during first same-sex experience. Emergent themes represented facilitators or barriers of condom use. Using a socioecological framework (Bronfenbrenner, 1992) we categorized themes into factors that impacted condom use on the individual, partner, and larger social level.

Condom Use

Individual themes—Nineteen participants described condom use during first anal sex experience and four described condom use during first oral sex (Table 1). These participants expressed three individual themes that emerged around condom use. Personal health experiences, including having had a recent diagnosis of an STI prompted use in six of the twenty-three participants. This participant exemplifies this relationship.

“I’ve always been the type to be like, “Hold on, do you have a condom?” And he’d be like, “No, let’s...” “No...get -move.” Like I have a strong sense of I don’t know how to say it, protection of myself because I just had walking pneumonia...” (Age at first sex: 14.5 years old, partner’s age: 15)

The participant’s recent diagnosis of pneumonia contributed to his proactive condom use.

Six participants described that a strong sense of self and personal pride dictated condom use, with youth describing that condom negotiations were based on a need to protect who they were as individuals. Condom use during sex and positive attitudes toward condom use was described as a reflection of their sense of self-concept and being in control of their life. This was closely associated with family influences that promoted such behavior.

“I don’t need no STDs, I don’t need HIV. Even though he probably was young and I knew he probably used condoms with females too, so I know we probably both was clean at the same time, though, but I’m overprotective a little bit. There’s things out here that you can’t get rid of, and I’m not with none of that.” (Age at first sex: 16 years old, partner’s age: 16)

This participant exemplified how using condoms during his first sexual experiences empowered him to take control of his fear about acquiring HIV or an STI.

Five participants described that condoms enhanced the sexual experience by directly impacting sexual sensation during anal sex. For example, this participant described that having a positive attitude toward condom use was associated with improved sensation around condom use during first anal sex.

“I always use condoms on anything, so, yeah, it was automatically condoms... I mean, a condom is just a piece of latex that covers your penis, so you still feel everything... And it’s actually better to use a condom, because it’s more easy to go in.” (Age at first sex: 16 years old, partner’s age: 16)

For these participants use of condoms helped to promote relaxation during sex partly because it provided a barrier but also because it promoted sensation and ease of the sexual experience.

Partner themes—Partner dynamics were the most important category for condom use. While three major themes emerged around use, introduction of condoms by partner was the most common theme (56%, n=13) among participants who reported use. Partners would be described as having a condom in their pocket or pulling out a condom as a way of introducing the idea of having sex for the first time. This quote is representative of participants who described how important it was to have a partner who had condoms. Further, the act of having condoms available contributed to use.

“He had Lifestyles, so I guess he already had it in his head planned that this was going to happen. So it was actually Lifestyle condoms.” (Age at first sex: 14 years old, partner’s age: 15)

Participants also related that a partners’ positive attitude toward condoms or partners who explicitly described a desire to stay safe facilitated this introduction.

Second, five participants (22%) described that more experienced partners, meaning partners who were not engaging in same-sex for the first time, provided guidance around sexual safety in relationships. More experienced partners who encouraged condom use were described as those who would take the initiative to insure the less experienced partner felt comfortable and this included condom use.

“It was like...I think more so he was more experienced than me. I never asked him. I don’t think that was his...would have been his first time ‘cause he had everything like, he made the timing right, he knew what to do, he knew kinda almost what I would like, so that I would feel comfortable and he had condoms.” (Age at first sex: 16 years old, partner’s age: 17)

Participants recounted such experiences made them feel comfortable using condoms and more comfortable promoting health protective behavior overall. Two participants described experiences where more experienced partners would warn them about possible transmission of STIs and HIV and importance of condom use.

Partner-specific factors were the third theme associated with use. Five participants described that having anal sex with a known HIV positive partner or a new acquaintance (someone randomly met) would be associated with condom use. Physical findings (uncircumcised penis) of the partner prompted use during oral sex. These partners were viewed as the riskiest partners who required consistent use.

Family, social & community influence themes—The first theme was the importance of mothers and older siblings as key members of social networks who encouraged condom use. One-third of participants commented on having a mother who discussed sexual safety and condom use as a critical part of sexual development and staying safe.

“Because my mother’s going to kill me. She got all them condoms in my drawer just to sit right there, so I knew for sure [to use a condom].” (Age at first sex: 16.5 years old, partner’s age: 18)

Other family members, like uncles and brothers, were also key to influencing and encouraging condom use during first same-sex, yet only a few youth described having such a

supportive male figure and no males described fathers as supportive during first same-sex experience.

“...my brother always used Magnums [condoms] so...Me, I was brung up on condoms.” (Age at first sex: 16 years old, partner’s age: 18)

Youth expressed social network factors, like having an HIV positive family member, also acted as key to using condoms and avoiding risk-taking behaviors.

The second community theme among users was receipt of health information (mostly in schools). Five youth described that health teachers, school counselors, and patient-providers provided some youth with exposure to condoms. A 14 year-old gay male, at time of first sex, whose partner’s age was 20, communicated exposure in school as,

“You know, that’s one thing they drill in your head in school, “Always use a condom. Always use a condom.” You know, I was scared for my health” (Age at first sex: 14, partner’s age: 20)

Provision of health information in schools regarding all types of sex, including oral-penile, anal-penile and oral-anal sex, however, was inconsistent in the rest of the sample.

Condom Nonuse

Individual themes—Sixteen participants described condom nonuse during first anal sex experience and forty-two described condom nonuse during first oral sex (Table 1). The most common theme that emerged around individual nonuse was testing frequently for HIV. Most (84%, n=42) of the participants described having been tested for HIV at the time of the interview. The most common frequency of testing was every 3–6 months (44%, n=22), followed by only when concerned of exposure (20%, n=10), and once a year (10%, n=5). Eight participants (16%) reported having never been tested prior to the interview. Among those who tested frequently (n=22), participants described that frequent testing provided them with a perception that their risk for HIV was low and they did not need to use a condom. One 18-year-old participant captured these phenomena by describing his condom use behavior currently and during his first few sexual experiences.

“I don’t use condoms and when I get tested and they tell me it’s negative it be really shocking. I be happy that it is negative because I don’t want HIV.” (Age at first sex: 13.5 years old, partner’s age: 13.5)

While this participant did not want to acquire HIV, he also did not want to engage in condom use consistently. In place of condom use, he relied on frequent testing to reassure him of his status and behavior. Other participants who used frequent testing in lieu of consistent condom use similarly described ambivalence toward condom use.

The second reason for condom nonuse was lack of health information about condoms. Only seven youth expressed having received health information in school that was applicable to their own same-sex sexual experiences. This quote, for example, describes how the lack of relevant sexual health information in school regarding anal-penile sex contributed to condom nonuse during first:

“I didn’t know the risk of not wearing condoms, because back then I thought that condoms were only supposed to prevent pregnancy, and I was like ‘I don’t need to use condoms. I’m gay.’” (Age at first sex: 17 years old, partner’s age: 35)

Such lack of information contributed to non-use with first partners during anal sex. All the participants who described not using condoms during oral sex described individual perceptions that STIs, including HIV, were not transmitted through oral-penile sex. Such a perception made condom use less necessary.

Discomfort during sex or change in sexual performance was the third reason for condom nonuse. Five participants described that condom use altered the sensation in the receptive position. For example, one of the participants described condom nonuse because in the receptive sexual position condoms often contributed to painful sex.

“I thought as though condoms-- I tried them before, but condoms, to me, when I was young, like it was too slipper-- my body is sensitive. And I always had sex raw. So when it goes in, it’s so slippery, and it hurts like I hate condoms.” (Age at first sex: 13.5 year old, partner’s age: 14)

Similar to this example, other participants described that condom use during sex altered the sensation of sex or made the sex too lubricated, which contributed to sexual discomfort. Substance use (alcohol and marijuana) also contributed to condom nonuse. Some young men described that substance use “makes sex better” by increasing arousal, but at the same time contributed to condom nonuse. Recreational use was described as contributing to nonuse particularly among youth who identified as bisexual. For example, one bisexually-identified participant describes this phenomenon, *“In every social setting with friends is always something drinking or smoking involved.”*

Other individual level barriers to condom use during first oral sex included negative attitudes and feelings toward condoms during oral sex. Participants described that the condoms had a “bad taste” or felt like “sucking on a balloon” as barriers to condom use during first oral-penile sex.

Partner themes—The most common theme (n=11) that emerged among nonuse with partners was trust in the romantic partner that the romantic partner was not having sex with other people. Participants described desiring to use condoms during first sex, but as the length of the relationship increased, heuristics like trust and intimacy altered individual perceptions of sexual risk resulting in condom nonuse.

“Of course it [condom] was used until I got...until I started feeling real comfortable and we both got tested at the same time. So, the first time and it was like on and off. Like, it will be times we would use it and then there’ll be times we don’t.” (Age at first sex: 16 years old, partner’s age: 16)

The sense of feeling comfortable in the relationship contributed to initial condom nonuse. Feeling comfortable was described as being associated with getting tested with one’s partner or seeing documentation (lab slip) that the partner was negative for HIV and other STIs. This is illustrated in the following quote.

“I’m not even going to lie. We had talked about it before and he had told me he was clean and showed me his papers. So he brought the condom but I was so caught up in the moment that I didn’t even see if he used it, and he didn’t. But I knew he didn’t have anything because he had showed me the paperwork the day that he got the test.” (Age at first sex: 16 years old, partner’s age: 20)

Having documentation that the partner was without a diagnosis of HIV or STIs provided some participants, like this participant, with the freedom to forget about potential risks and hesitation to use condoms.

Sexual position was also an important factor in condom nonuse. Most (77%, n= 27) participants described being the receptive partner during first same-sex and described “sometimes” condom use (n=26, 54%) during their first few same-sexual experiences. Among participants who described inconsistent condom use condom use was slightly more often during sex in the receptive position (n=10) than in the insertive sexual position (n=6). Participants who described using condoms always during receptive sex but not consistently during insertive sex described nonuse because of a perception of greater risk for HIV in the receptive position.

Five participants described having unplanned first anal or oral sex and this contributed to condom nonuse. These participants described using physical assessment (examining genitalia or relying on the partner’s physical features like attractiveness) or using “sense” to determine if a partner posed a sexual health risk.

“I mean, I always had like a sixth sense to see like who’s dirty or not. Like I can just always tell; If I feel like you have something, I wouldn’t do anything with you. If I feel like you’re clean, then I would. It’s kinda weird. I’ve just always been right...” (Age at first sex: 15.5 year-old, partner’s age: 17)

This quote is representative of participants who reported using feelings to determine whether a partner “had something” like a STI and to decide whether condoms should be used or not. Participants for which this approach worked continue to use this strategy in subsequent partnerships.

Family, social & community influence themes—Larger network factors such as limited access to condoms, encouragement from friends to not use condoms because of improved sensation and inability to communicate with family or parents about same-sex sexual activity also contributed to condom nonuse. Five participants described that friends or sexual networks encouraged nonuse to for the purpose of improving sensation. This participant’s quote captures how social networks influenced condom nonuse.

“Like, and a lot of people tell me because I never had unprotected sex but like without the condom it’s like great, it’s the best.” (Age at first sex: 14.5 year old, partner’s age: 11)

While such network influences were not uncommon among condom nonusers, condom nonusers further portrayed a general lack of parental discussion about condoms and such discussions significantly contributed to nonuse and being not prepared to use condoms

during first anal sex. Only seven participants described having received health information from their parents or schools.

“...I was a novice to it. I was never told to wear condoms...Yes, that’s not something that my parents would even think...and it wasn’t on my mind until it was brought to my attention.” (Age at first sex: 12 year old, partner’s age: 15)

Participants who described an inability to talk to parents about condoms also described simultaneously not receiving school health information about condom use during male-to-male sex.

“I didn’t know about HIV and stuff like that till not even health class, because I don’t think health class talked about HIV and STDs.” (Age at first sex: 17 years old, partner’s age: 35)

While this participant did not specifically recount difficulty negotiating condoms during first sex, the significant difference in partner’s age from the participant’s age suggests that an age-discordant dynamic may have also contributed to nonuse. Limited condom use was perpetuated not only by limited knowledge about use but also limited self-efficacy to use condoms during male-male sexual relationships.

We did not find that younger age at first anal sex (14 years old) in itself factored into more descriptions of condom nonuse. Instead, we found that participants who reported younger age at first anal sex (14 years old) described having been influenced more by larger societal and social factors (for example, exposure to condoms in school, from parents, or social networks) and this often-influenced use or nonuse. Sexual network and aspects of sexual satisfaction or arousal influenced use and nonuse in all age groups.

Discussion

These interviews represent an important step in understanding condom use and nonuse during first same-sex in a sample of YBMSM. The mean age of sexual debut in this sample was just under 14 years old. This age is slightly younger than sexual debut ranges in other literature (Halkitis et al., 2011; Kaplan, Jones, Olson, & Yunzal-Butler, 2013). Early onset of first sex has been associated with negative health outcomes including the acquisition of STIs including HIV, depression, substance abuse, truancy, sexual violence, and coercive sex (Else-Quest, Hyde, & DeLamater, 2005; Kaestle, Halpern, Miller, & Ford, 2005). Our sample reported a range of sexual debut ages from 10 to 17 years old and reported inconsistent condom use during first anal-penile sex, regardless of age at first sex, and essentially no condom use during first oral-penile sex.

Half of the participants described condom use during first anal sex. The key reason for condom use in this sample was partner influence. Participants who had partners who encouraged condom use or had condoms available were more likely to describe using condoms during first sex. Prior studies in adolescents and young adults 18–24 years old suggests that condom use is dictated by partner factors like masculinity, older partner age, insertive sexual position, and or experience of the partner (Fields et al., 2012; Arrington-Sanders, Leonard, Brooks, Celentano, & Ellen, 2013). Most participants in this sample

described similarly aged partners during first same-sex experience and so partner age did not impact condom use behaviors in this study. It may be that young men may be more likely to discuss condom use and use it if it is available with same-age than age discordant partnerships where youth are less able to negotiate condoms (Fields et al., 2012).

We found that participants commonly described that women (mothers, older aunts, or sisters) were key sources of support and information about sexuality, sex and condom use during first sex. Very few men, however, described a supportive male family member who encouraged condom use during first same-sex. The young men who reported a supportive male figure described gaining some condom-use role modeling from those interactions. Hussen et al. (2014) has suggested that Black father figures may be more likely to introduce heteronormative scripts to adolescents that further isolate and may exacerbate or attenuate sexual risk behavior in YBMSM. Youth who do not have supportive roles models may experience social isolation that is created in heteronormative households. This, in addition to a lack of preparation to use condoms, may predispose them to engage in risk behavior (Torres et al., 2013).

Most (92%) of participants described condom nonuse during oral sex and nearly half (46%) of participants described condom nonuse during anal sex. Condom nonusers described using HIV testing as a behavior strategy in place of condom use. While other research has suggested that event-driven (experiencing symptoms post recent sexual encounter, engaging in high risk sex) factors drives regular HIV testing in YBMSM (Mimiaga, Goldhammer, Belanoff, Tetu, & Mayer, 2007), some young men may be using frequent testing as preventive strategy that promotes engaging in condom nonuse. Other prevention strategies were based in the (incorrect) perception of absent HIV risk for oral-penile sex or in belief that use of physical assessment was an accurate assessment of risk.

Very few participants described having received information about same-sex activity prior to engaging in first sex. Youth described a deficit of information in schools and not feeling able to discuss behavior with parents. The lack of parental knowledge and an inability to communicate with parents about condom use, coupled with a lack of sexual education about male-male sex prior to first same-sex, may contribute to condom nonuse and young men's HIV risk. Youth advocates, policy makers, clinicians and parents should work to ensure safe spaces are available to provide adequate sexual health information to youth about same-sex experiences and how to protect one's self prior to first sex. It may be that youth who have not been provided adequate access to information and resources about same-sex experiences may lack the self-efficacy to use condoms in sexual relationships. Lack of sexual education has been a frequent area of deficit for prevention in young same-sex attracted men (Forrest & Silverman, 1989; Telljohann, Price, Poureslami, & Easton, 1995; Blake et al., 2001).

Ten participants described strategically making a decision about condom use based on sexual position, with more use in the receptive than in the insertive role. Such seropositioning, a preventive strategy that is presumed to have lower probability of acquiring HIV infection in the insertive sexual position than in the receptive sexual position, has been used as a seroadaptive behavior in other samples of men who have sex with men (Snowden, Raymond, & McFarland, 2009; Golden, Stekler, Hughes, & Wood, 2008; Snowden et al.,

2009; Vallabhaneni et al., 2012). In lieu of limited sexual health information demonstrated in this study and others (Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010), seroadaptive behaviors may be a key strategy used by YBMSM to lower one's risk for HIV acquisition.

External forces, such as gay-related stigma or rejection, may cause some YBMSM to engage in condom nonuse as a form of intimacy and trust, reducing risk of future rejection (Preston et al., 2007). Participants did not explicitly describe stigma or internalized homonegativity associated with condom nonuse in this sample. Instead, individual and partner-specific factors prompted both condom use and nonuse. Individual factors such as a desire for pleasure and increased sensation increased likelihood of condom nonuse. Desire for pleasure and satisfaction has been suggested as a driver of condom nonuse in YMSM (Mor & Dan, 2012; Parsons, Lelutiu-Weinberger, Botsko, & Golub, 2013) may help some youth to cope with such social stressors (Bauermeister et al., 2009). This was sometimes associated with substance use.

Studies have suggested that some black MSM use of substances to facilitate sexual experiences and to promote sexual performance and such use is related to expectancies of use to enhance the sexual experience (Bimbi et al., 2006; Kalichman, Tannenbaum, & Nachimson, 1998). We found that recreational substance use common among participants who identified as bisexual and this often led to condom nonuse. This is in-line with other work suggesting that men who have sex with men and women (MSMW) are more likely to engage in substance use overall, sex while intoxicated, and condom nonuse than men who exclusively have sex with men only (MSMO) (Jeffries & Dodge, 2007; Heckman et al., 1995). Some have suggested this occurs particularly among black MSMW as a result of higher internalized homophobia, lower social support and higher depression (Dyer et al., 2013).

Other participants in this sample described seeking increased sexual sensation with condom use, suggesting that more work is needed to understand what drives sexual satisfaction in these groups in order to better promote sexual pleasure and satisfaction during sex with a condom. It may be that other factors, such as a strong self-concept and feeling that condoms provide protection leads to alleviation of anxiety that simultaneously encourages use and sexual pleasure for some, while other factors such as expectancies of pleasure, psychological disenfranchisement, and isolation promote nonuse.

A casual sex partner was a key reason for use, unless the participant described being unprepared for first sex, whereas condom nonuse occurred commonly in participants who described being in a long-term relationship or dating someone. This is in-line with other work that suggests when in romantic relationships young men may employ heuristics such as engaging in condom nonuse with known and trusted partners that are viewed as safe while engaging in condom use with unknown partners (Elford et al. 2001; Thorburn et al. 2005). We found that participants combined concepts of trust and intimacy with either being tested together or seeing documentation ("papers") of someone's HIV status resulting in inconsistent condom use.

The results of this work should be viewed in light of limitations of the data collected. Most of the sample self-identified as gay or bisexual so some of these findings may not generalize to Black or African American young men who have sex with men who do not identify as gay or bisexual. A plurality recruitment approach was used to recruit participants as this approach tends to be more representative of the population than one strategy (McCormack, 2014). Still, the findings of this work may not transfer to all black or African American gay and bisexual men given participants recruited through different venues may have different levels of homonegativity that may influence condom use decisions during first same-sex. Additionally, this sample is a cross-sectional view of condom use during first same-sex. It does not examine how condom use changes over time within relationships or specifically examine time between first condom use and subsequent testing behaviors. This work did not examine sexual debut with female partners, which may additionally play a role in condom use decisions. In spite of these limitations, these data provide an important first step into understanding how YBMSM may use condoms during first same-sex sexual experiences and what factors may be impacting condom use.

More work is needed to explore the drivers of condom use during first sexual experiences. The young men in this sample suggest that multiple strategies are being used to promote and inhibit condom use – including use of seroadaptive preventive strategies. Given the advent of biologically effective interventions such as pre-exposure prophylaxis, more work will need to incorporate condom use with effective strategies that protect YBMSM during first sexual experiences. Both will require providers, parents and public health practitioners to educate young men about biomedical and comprehensive HIV primary prevention services that include access to behavioral counseling specific to same-sex attracted youth, free condoms, and regular HIV testing. A comprehensive behavioral strategy that incorporates key facilitators and inhibitors of condom use is needed. The sexual health model, proposed by Robinson (2002) is one such model that has the potential to improve the health outcomes of YBMSM. Despite demonstrating increase in condom use during anal sex (Rosser, et al, 2010), it has not been incorporated widely into current preventive strategies.

Public health prevention strategies must be designed to promote partner factors that encourage condom use while also addressing the lack of information about condom use during first same-sex experience, inadequate parental or family preparation to provide support and counseling related to sexual development and behavior, and use of less effective risk reduction strategies as a replacement for consistent condom use. Effective programs will need to support same-sex attracted youth prior to first same-sex experience so that they are armed with accurate sexual health information about pleasure and STI and HIV risk across types of sexual activity and empowered to negotiate risk reduction strategies as they explore their sexuality and navigate new relationships.

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TABLE 1

DEMOGRAPHIC CHARACTERISTICS OF THE STUDY POPULATION (N=50)

CHARACTERISTIC	N	MEAN (SD), %
Mean age		17.6 (1.3)
Race		
Black or African-American	48	96%
Other	2	4%
Sexual Orientation		
Gay or homosexual	31	62%
Bisexual	17	34%
Other (including not defined, heterosexual)	2	4%
Mean age of 1st Same-Sex experience		13.9 (2.6)
Mean age of partner at 1st Same-Sex		16.6 (5.5)
Mean number of lifetime sexual partners		13.3 (14.5)
1st Same-Sex Penetrative Experience		
Oral-penile	15	30%
Penile-Anal	4	8%
Oral-penile and Penile-anal	31	62%
Sexual Position During Penile-Anal Sex		
Insertive	4	11.4%
Receptive	27	77.2%
Versatile	4	11.4%
Condom use at 1st Same-Sex experience		
Oral-Penile (n=46)		
Yes	4	8%
No	42	92%
Penile-Anal (n=35)		
Yes	19	54.3%
No	16	45.7%
Condom Use Overall (N=48)		
Always	19	40%
Sometimes (N=26)	26	54%
Use only in the Receptive Position	10	38%
Use only in the Insertive Position	6	23%
Use did not vary by sexual position	10	38%
Never	3	6%
Partner Type		
Friend	31	62%
New Acquaintance	10	20%
Dating	6	12%
Anonymous	2	4%
Neighbor	1	2%

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CHARACTERISTIC	N	MEAN (SD), %
Recruitment		
Sexual Networking Application	11	22%
Snowball Sampling	21	42%
School-Based Health Clinics	3	6%
Adolescent Health Clinics	11	22%
Community Venues	4	8%

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TABLE 2

IN-DEPTH INTERVIEW SAMPLE QUESTIONS

DOMAIN	
First Sex	How did you know you were ready to have sex? When did you decide you wanted to have sex with this person? What did it mean to you to feel attracted to this person? Tell me about what happened in this situation. How were condoms introduced into the situation? Describe how condoms or other types of protection were involved and who made that decision.
Sexual Risk	Did either you or your partner have a sexually transmitted infection or HIV at the time of the sex that you know of? What about this situation made it risky?
Social Context	Tell me about whether your decision to have sex was affected by anyone or anything or messages you may have been hearing about having sex with a man.
Facilitators, Supporters, Mentors	Other than your parent, has there been an important person in your life, who is older and more experienced than you and has provided you with guidance and support as a [SI [‡]] individual? Tell me about how your parents or family members were helpful or not helpful when you came out. When you first started to identify as [SI [‡]], who was helpful and supportive in this process?

[‡]SI – Defined as sexual identity. Participants were asked to describe how they define themselves sexually in terms of attraction, identity and behavior in another part of the interview.

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