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“I Don’t Have a Problem With It, But Other Guys Do”

An Exploration of Condom Negotiation among
Young Black Men Who Have Sex with Men in the South

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ABSTRACT—Condom negotiation among young Black men who have sex with men in the Southern United States was explored using the theory of reasoned action. Fifty-four (18- to 29-year-old) males participated in nine focus group interviews. Discussions elicited condom use and negotiation attitudes, beliefs and social norms. Positive personal attitudes (respect of self, personal health concerns) and high negotiation self-efficacy was emphasized. Conversely, social norms revealed non-prioritized condom use behavior. Divergence between individual and community indicates theoretical models targeting sexual communication must address external factors (social, economic, political context), which intersects with individual intentions, attitudes to influence HIV prevalence in this community.

KEY WORDS—Blacks; young men; condom use; communication; high-risk sex; HIV/AIDS; theory

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Introduction

THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) estimate that Blacks Americans bear the greatest burden of HIV in the United States. Nationally, Blacks account for 44 percent of all new HIV infections in 2009, although they constitute only 14 percent of the U.S. population (CDC, 2014). By race and risk group, young Black men who have sex with men was the only population in the United States to experience a statistically significant increase in new HIV infections between 2006 and 2009 (CDC, 2012). Results of a six-city survey of MSM aged 15–29 years showed that 91 percent of young Black MSM were unaware of their HIV infection status, compared with 68 percent of Hispanics and 60 percent of whites (CDC, 2008).

The dramatic increase in HIV incidence observed among young Black MSM is likely fueled by many factors including very high background incidence and prevalence of sexually transmitted infections (STIs) in this population indicating the necessity for developing a targeted intervention to reduce HIV/STI risk. Although biomedical innovations are gaining efficacy in the United States, condom use remains as the frontline defense against the HIV/AIDS pandemic and has the potential of reducing the transmission and acquisition of other STIs (Crosby, 2013). Communication about condoms is an important precursor to use (Bowleg, Valera, Teti, & Tschann, 2010; Diclemente, 1991; Noar, Morokoff, & Redding, 2001). A meta-analysis found partner communication about condom use to be the strongest correlate of subsequent use when compared with other intrapersonal factors (e.g., attitudes toward condoms, barriers to use) (Noar et al., 2006). This suggests promise in tailoring behavioral HIV risk-reduction interventions designed to improve communication about condom use to high-risk groups such as young Black MSM.

The Theory of Reasoned Action (TRA)

The theory of reasoned action (TRA) has proven useful in predicting individual intention to use and negotiate use of condoms (Albarracín et al., 2001; Bennett & Bozionelos, 2000; Fishbein & Ajzen, 1975). TRA holds that an individual's intention to perform a behavior (e.g., negotiate condom use) is the best predictor of subsequent behavior. Intention can be assessed in terms of attitudes toward the behavior and perceived social norms about performing the behavior. In 2000, Fishbein included the construct of self-

efficacy as an additional predictor of intention in a model specific to behaviors relevant to STI and HIV prevention (Fishbein & Pequegnat, 2000).

In the current study, we explored condom use and negotiation among young Black MSM through use of the TRA. Previous studies demonstrated that individual condom acceptability issues may interfere with a desire to practice safer sex (Harawa, Williams, Ramamurthi, & Bingham, 2006). Peer support for condom use decreases the likelihood of HIV sexual risk behavior among Black MSM, and significantly lower perceived condom use approval in social and sexual networks is evident (Bakeman & Peterson, 2007; Jones et al., 2008; Peterson, Rothenberg, Kraft, Beeker, & Trotter, 2009). Low condom use self-efficacy (i.e., high likelihood of giving in to partner's desire for unprotected sex) is associated with HIV infection in this population. To our knowledge, no studies have applied a theoretical framework to examine personal attitudes, self-efficacy, and social norms in tandem.

Methods

Young men presenting for STI/HIV screening or treatment to an urban public-funded STI clinic in Mississippi were screened for eligibility by clinic staff after receiving clinical care and were invited to participate. Participants were also recruited from a local community-based LGBT outreach organization during sponsored programs and events. Young men were eligible to participate if they 1) were 18–29 years old; 2) self-identified as Black/African-American; 3) reported penile-anal sex with a male partner in the past three months. Following informed consent procedures, nine focus group discussions were conducted with young Black MSM (*N* = 54) between November 7 and 9, 2011.

The focus group discussion guide is listed in Table 1.

Table 1. Focus Group Interview Guide, African-American MSM aged 18–29

Part 1

- 1. How do you interpret being asking to use a condom/what does it mean to you?
- 2. What are your “rules” about condom use?
- 3. Have you ever thought about using the female condom for anal sex?

4. How confident do you feel in your ability to apply condoms correctly? What are some of the mistakes you have made in the past few months?
5. If you were given a variety of condoms and lubricants to try at home (with or without a partner) and asked to provide feedback, would you be willing to do that?
6. What do you need to practice safer sex?
7. Do you feel comfortable asking your partner to use a condom? Confident?
8. What would help you intensify an orgasm while using condoms?
9. How would you handle the following situations . . .
 - a. Your partner is STI positive.
 - b. Your partner is HIV positive.
 - c. You are unsure of your partner's STI status.
 - d. You are unsure of your partner's HIV status.
10. Do you feel that homophobia ever interferes with you having safer sex? Please elaborate in detail.
11. Some MSM say that condom use is a way to express "self-love." Please describe how you feel about this statement.
12. How important is an orgasm in the sexual experience with other men?

Part 2

13. What are the "rules" about condom use among MSM in Jackson?
14. Do MSM in Jackson use condoms for oral sex? Why or why not? If so, do they use flavored condoms for oral sex?
15. Where do the majority of young (under 30) MSM in Jackson find potential partners (e.g., clubs, Internet, etc.)? Where do they have sex?
16. Do men in Jackson discuss STI/HIV status prior to the initial sex act? If so, under what circumstances do these discussions occur and how do these differ based on local status (e.g., gay family member, late, trans, trade, bougie, etc.)?
17. Do young (under 30) MSM in Jackson frequently skip condom use for anal sex to "prove love"?

Part 3

18. Do you ever attempt to determine if someone is HIV positive just by looking at them? What do you look for?

Part 4

19. What type/brand of condoms do men in Jackson prefer?
20. What type/brand of water-based lubricant do men in Jackson prefer?
21. For research study educating MSM about the importance of correct and consistent condom use/STI risks, please provide a description of what the ideal “health educator” would look like (e.g., race/ethnicity, age, gender, etc.)?
22. What is your preferred method of contact (e.g., email, text, etc.)?
23. Where do you get condoms? Do you have a variety? Are condoms expensive in your area?
24. Would you feel comfortable having your STI test results delivered via text message (e.g., 0 = everything is fine; 1 = call the clinic)?

Discussions were facilitated in a quiet private room within the clinic to ensure participants’ privacy and confidentiality. Groups ranged in size from 4 to 12 participants per session. The duration of each discussion lasted between 45 minutes and 1.5 hours. Focus group discussions were moderated by one or two moderators who were assisted by a note-taker with experience in focus group discussion settings.

Data Analysis

After transcription, the data were imported into NVivo 9 software for coding and categorizing (NVivo, 2010). After several line-by-line readings, key categories and themes from the participants’ narratives were developed. The codes were analyzed using a grounded theory approach (Glaser, 1992). Coding was performed by two coders and was assessed for consistency and inter-coder reliability. The calculated inter-rater agreement was in the 90th percentile range. Finally, after initial coding was completed, constructs from the TRA model were then used to thematically analyze responses. The data were interpreted within the TRA model framework and NVivo quotations were selected to illustrate particularly vivid examples of emergent themes throughout the subsequent discussion of the resulting data. This

protocol was revised and approved by the University of Kentucky Institutional Review Board.

Results

Attitudes

Of the three predictors of intention, attitude was most often expressed in positive terms. To these young men, being asked to use a condom indicated prioritization of partner and personal health. For example, when asked about his reaction if he were to be asked to use a condom by a male partner, one young man said:

I look at it as a positive thing because they looking out for the both of us. They want to make sure that we stay protected, make sure we stay healthy and I feel like that's a good thing if somebody asks.

Initiating a discussion about condom use seemed to indicate attainment of a certain level of sexual education ("or they [at least] know a lot about different STIs and HIV"), according to another young man. Almost every person also associated an ethic of respect with condom use negotiation. According to one young man:

When asked the question [about using a condom], that makes me feel that they have a sense of self-respect for themselves. Meaning they don't lower themselves and just do whatever with whomever. That makes me know that they are safe, not just with me but their previous encounters. So basically they care about my life and theirs.

General attitudes about condom use underscored these positive attitudes toward negotiation. Although a few men reported problems with effectively using condoms, many reported enjoying sexualizing condom use, particularly with main partners. The opportunity to experiment with varying textures, flavors, colors, and sensations of lubricants and condoms "stimulated enough it doesn't matter" whether a condom was being used. Even for those men who did not mention pleasure in sexualizing condom use, almost all of the men described personal rules for condom use that included: "using them at all times;" "if you ain't got no rubber, you don't get to tap;" and "condoms are like my best friend—I should wear one like I wear socks, pants, and shirts." Respondents clearly understood that consistent condom use reduces the risk of STI/HIV transmission.

Several young men maintained positive attitudes toward negotiating condom use regardless of whether a partner's STI or HIV status was disclosed ("I treat everyone as if they are infected with something, anything, everything. And I just feel like you should protect yourself first so you should treat everyone as if they are infected.") or whether they are engaging with multiple partners in a single time period ("I think that actually makes me want to use condoms more, by having multiple sexual partners; I think that's when you're most prone to use condoms."). To these men, condom use was a necessary aspect of any sexual encounter, revealing that these men shared a de-stigmatized and overwhelmingly accepting attitude toward condom use.

Self-Efficacy

Consistent with patterns emerging from analysis of young men's personal attitudes, focus group discussions about self-efficacy to negotiate condom use were also characterized by positive outlooks. Men expressed high levels of self-efficacy in their ability to discuss condom use with a partner. A few indicated that they "took classes in high school that showed them how" to negotiate condom use. However, the majority of these young men seemed to have "on-the-job training" rather than learning about condom use negotiation through formal sexual education classes in school. In voicing a common theme from the focus group discussions, one man said, "I've been through encounters where I did have to bring it up myself so I think I can do it." When asked about the rationale for their feelings of confidence in performing this behavior, no individual offered any concrete examples, other than school education and general positive attitudes toward sexual health.

Willingness to initiate condom use communication was a theme on which many respondents touched. For example, one man said, "I wouldn't never wait for nobody to make the first move or ask, I will always be prepared if I'm going to be in that situation," demonstrating sentiments shared by several of these young men. In fact, condom negotiation seemed to be related to personal responsibility, as exemplified in the following young man's comments:

I tell people all the time that you should always protect yourself and never rely on anyone else to protect you. I believe you should treat every sex partner as if they are infected and protect yourself by learning how to talk about using a condom. If I contract HIV or any kind of STI, I'm

going to blame myself because I feel like it was more my fault then it was the individual's—I should be responsible enough to protect myself first.

Among these men, the sense of confidence in initiating and communicating directly about condom use demonstrates high levels of self-efficacy consistent with their positive attitudes toward the necessity of engaging in condom negotiation with sexual partners.

Social Norms

In contrast to personally-held positive attitudes and high levels of self-efficacy, men converged on an overwhelmingly striking consensus that communicating about condom use was not a priority in their community. This was best illustrated by the statement of one man, “I don’t have a problem using condoms or asking my partner to, but other guys do.” In general, the partners of these young men infrequently initiated discussions about condom use. As one young man said, “most dudes in [study city] won’t ask you to use a condom. If you don’t say, ‘well I want to use a condom,’ they won’t.” Self-efficacy in initiating sexual communication is necessary in the face of these unsupportive social norms; according to another man, “sometimes it’s like they waited for you to ask . . . make the first move. You don’t say nothing first and they don’t say nothing first, it just goes right on in.” Although several of the young men verbally expressed self-efficacy in negotiating condom use, in the face of opposing social norms actual communication and condom use behavior might be inconsistent, likely leaving these young men prey to STI and HIV transmission.

In this community, asking a partner to use a condom might be associated with a perception of passive self-disclosure of a positive HIV or STI status. When asked his perception of why sexual communication about condom use is low in his community, one man said:

[. . . that he did not] think it’s because of the fear of catching STIs or any kind of disease. It’s just the fact that people feel uncomfortable asking someone because some people feel like if you ask someone they would be like, “What’s wrong with you, you have something?”

If condom negotiation is linked with an assumption of a positive STI or HIV status, then it might be easier to understand the perceived reluctance individuals described encountering sexual partners within this small community. Avoiding the “infected” label was important in defying stereotypes (as one young man said, “People relate homosexuality or gay males to them having

an STI or mainly HIV and I wouldn't like to be a statistic so it makes me want to always protect myself.”) and to avoid negative perceptions from peers.

These conversations also suggested that an additional factor underpinning social norms was the belief that condoms physically and psychologically detract from sex. For some men, condoms served as sexual detractions. In his experience, one young man shared that “there’s been times where [partners say] we don’t have to use a condom because [condoms] hurt and they don’t want to use it.” Another respondent noted:

I think the breakdown occurs with the mechanics of . . . you’re [having sex to] feel good. This is like a basic human instinct, a human right to connect with another human being on a physical, emotional level. And so it’s like the condom, that barrier, is somewhat robbing you of that experience and people are almost willing to sacrifice or jeopardize their health and their well-being to have that. Is it stupid? Hell yeah. Will they regret it? Probably. But [it’s difficult] balancing that human instinct and balancing the want to protect and prevent.

In summary, these data indicate an apparent contradiction of themes emerging from the analysis of personal attitudes, self-efficacy and social norms. Men expressed a clear distinction between their own positive attitudes toward and self-efficacy in negotiating condom use and the negative social norms they perceived as prevailing in their community.

Discussion

This qualitative study of young Black MSM in Mississippi was conducted to elicit informative insights regarding how men in this at-risk population perceive condom negotiation and subsequent condom use. Analysis of the data indicated that for these men, employment of a basic TRA model might not be effective in predicting intention to negotiate condom use with sexual partners. The contradictions between messages about personal attitudes and ability and social norms might indicate that external factors, and their relative influence on condom negotiation, might also need to be considered in the application of the TRA model. This conclusion corroborates previous evidence showing that consideration of life context might be necessary to fully describe intention to use condoms among young Black MSM (Beadnell et al., 2007). Indeed, contextual factors such as experiences with stigma and homophobia are central to HIV risk among young Black MSM as they

impact willingness to seek HIV prevention and care, support from family and community, decision-making about sexual behavior, and substance abuse (Balaji et al., 2012; Oster et al., 2011). Failing to reconcile conflicting elements of stigma, personal beliefs and outward appearances might cause these men to internalize homophobic attitudes which may impair their willingness to contest prevailing social norms that discourage sexual communication and condom use.

One of the key strengths of qualitative research design and the phenomenological approach is the rich narrative elicited, especially in exploring under-researched issues like condom negotiation among young Black MSM living in the Southern United States. This sample of fifty-four young men reflects a wide range of experiences, perspectives, and behaviors relevant to our research question. Young men in this study described individual attitudes and self-efficacy as strongly related to intention to negotiate condom use with sexual partners. However, social norms in the local young Black MSM community seem to undermine this intention. Results of the recent study by Oster (2011) suggest that observed low condom use self-efficacy and a high likelihood of giving in to a partner's desire for unprotected sex was associated with low rates of condom use and HIV infection among young Black MSM living in Jackson, Mississippi (Crosby, Holtgrave, DiClemente, Wingood, & Gayle, 2003). Oster offered the possible interpretation that for these young men, condom use negotiation may differ by partner type (i.e., long-term partner, new, casual). This finding corroborates a likely role for interventions that focus on improving sexual negotiation skills or for partnership counseling approaches.

The disconnect between attitude, self-efficacy, and social norms may be better understood through the inclusion of external factors such as substance abuse, incarceration history, HIV status of participants and their sexual partners, local social capital, and partner norms in an expanded TRA model. For example, evidence shows that social capital (e.g., membership in social organizations) has been associated with sexual risk behavior among youth (Helliwell & Putnam, 2004; Ramirez-Valles, Zimmerman, & Newcomb, 1998). Of all 50 states, Mississippi ranks 49th on the social capital index (Helliwell & Putnam, 2004). In consideration of this abysmal social capital score there is room to question how this structural factor might play into HIV risk for young Black MSM. The intersecting influences of external factors such as this on individual intentions and attitudes might help to explain the low rate of condom use and high rate of HIV prevalence in

this community, as the enactment of individual beliefs is often complicated by sociocultural factors.

Additionally, Davison's third-person effect hypothesis offers an alternative perspective to aid understanding of the contradiction between attitudes and social norms reported in this article (Davison, 1983). The conceptual underpinning of this hypothesis is that a persuasive communication or concept will have the strongest effect on "them" (the third person), not "me" (the first person) or "you" (the second person). In this study, participants may have perceived other men in their community as being more susceptible to negative perceptions of condom use (e.g., condoms diminish pleasure, condom negotiation indicates a positive HIV or STI status) and thus reported on social norms accordingly. Also, as the third-person effect hypothesis assumes that much of our social behavior is dictated by perception of reality, perceiving an underlying anti-condom sentiment in the community might feed back into personal behavior causing inconsistent or ineffective condom negotiation behavior (Price, 2009).

Results of this study should be interpreted in light of limitations. First, these results cannot be generalized. Second, recruiting from an STI clinic population might offer an over-representation of young men who perceive themselves at high risk for STIs but may forgo primary prevention (condom use) for secondary prevention (seeking treatment). Third, focus groups might have limited what men were willing to share with the interviewer thereby providing a less-than-complete disclosure of men's beliefs and practices.

Our study found a significant number of young Black MSM expressed overwhelmingly positive attitudes and moderately high self-efficacy for condom negotiation. Conversely, reported social norms within the local young Black MSM community conflicted with these messages, alluding to the influence of unidentified external factors that should be considered in an expanded TRA model for condom use negotiating behavior. Many have noted the theoretical insufficiency of social cognitive health behavior theories such as TRA in capturing contextual factors associated with health behaviors; the social, economic and political context of young Black MSM condom use is one of those situations (Barta W. D., 2008; Buffardi, Thomas, Holmes, & Manhart, 2008; Burke, Joseph, Pasick, & Barker, 2009). Given the promise of improving condom negotiation as a strategy to reduce HIV risk, behavioral scientists working with young Black MSM should consider how an expanded TRA model could be employed to assess intention to communicate about condom use.

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