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Sexual Partnerships, Risk Behaviors, and Condom Use among Low-Income Heterosexual African Americans: A Qualitative Study

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Abstract

The purpose of the current investigation was to contextualize the sexual relationships and risk behaviors of heterosexually active African Americans. A total of 38 participants (20 females and 18 males) aged 18–44 years were recruited in a large city in the southeastern U.S. to participate in focus group discussions exploring sexual partnerships, general condom perceptions, and condom negotiation. Results indicated that participants distinguished among at least three partner types–one-night stand, "regular" casual partner, and main partner. Partner types were found to shape and influence types of sexual behaviors, perceptions of risk and condom use, and condom negotiation. Participants also shared general perceptions about condoms and elucidated situations in which intentions to use condoms were not realized. Gender differences emerged in many of these areas. Implications of these findings are discussed and directions for future research on sexual partnerships and risk behavior are offered.

Keywords

sexual behavior; HIV prevention; condom use; African Americans; partner type; relationship

INTRODUCTION

While African Americans make up just 14% of the U.S. population, they accounted for 44% of new HIV infections in 2009 (Centers for Disease Control and Prevention [CDC], 2011). Recent data indicate that rates of new HIV infections among African Americans are almost 8 times higher than their White counterparts (CDC, 2011). High-risk heterosexual contact as a route of HIV transmission is also high among African Americans. For example, in 2005, 80% of cases in women and 25% of cases in men were due to high-risk heterosexual contact (CDC 2007b). Given these troubling figures, the CDC has recently called HIV/AIDS among African-Americans a "major health crisis" and issued a "heightened national response" to this crisis, which includes a call to develop new interventions (CDC, 2007a).

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The dramatic HIV/AIDS health disparity among African Americans is the result of complex and intersecting historical, structural, environmental, and cultural factors (CDC, 2007a). Racism, poverty, and gender intersect in ways that heighten the risk of heterosexual transmission of HIV/AIDS in many African American communities. For example, disproportionate numbers of African Americans are incarcerated and incarcerated populations have higher rates of HIV infection than the general public. Incarcerated men and women are particularly vulnerable when they engage in high-risk behaviors, such as injection drug use, and incarceration disrupts the stability of sexual partnerships and relationships, which can increase sexual concurrency (Gaiter & O'Leary, 2010). High rates of incarceration, along with a lack of jobs and lower life expectancy rates for African American men, contribute to a gender ratio imbalance in many communities. In fact, as of 2002, African American women ages 25–44 outnumbered African American men by almost 20% (Black AIDS Institute, 2005). Gender ratio imbalances can create an imbalance of power in heterosexual relationships which makes it difficult for African American women to engage in protective behaviors while trying to maintain heterosexual relationships (Ferguson, Quinn, Eng, & Sandelowski, 2006).

Stigma and denial are also factors influencing the heterosexual transmission of HIV/AIDS in African American communities. The stigma attached to HIV/AIDS discourages individuals from getting tested and limits discussions about the epidemic. Since HIV/AIDS was historically presented as affecting gay White men, some African Americans may still view the epidemic as something outside of their communities, leading individuals to deny they are even at risk of contracting HIV (CDC, 2007a).

The number of factors that intersect to heighten HIV risk for African Americans is at times overwhelming. Given that many of these factors are structural in nature, one clear conclusion is that interventions at the structural and community level are an increasingly important direction for prevention efforts (Adimora, Schoenbach, & Floris-Moore, 2009; Blankenship, Friedman, Dworkin, & Mantell, 2006; Peterson & Jones, 2009). More traditional behavioral prevention efforts remain important, however, especially in contexts that serve large numbers of at-risk African American clients, such as sexually transmitted infection (STI) clinics. We would argue that prevention efforts would be greatly strengthened to the extent that they understand and contextualize African Americans' sexual relationships. Without such a contextual understanding, prevention efforts may fail as they attempt to persuade African Americans' to engage in safer sex practices without reference to how they experience and perceive sexual partnerships (Wyatt, Williams, & Myers, 2008).

Heterosexual African American Relationships

A steadily growing body of literature has focused on contextualizing African American heterosexual relationships and risk behavior. For example, compelling epidemiological studies suggest that, within rural Southeastern communities, some African American individuals participate in concurrent sexual partnerships, potentially increasing the rate of STIs, including HIV (Adimora et al., 2003, 2004). Qualitative studies of largely African American STI clients and urban dwelling adults have suggested that partner concurrency is viewed as normative in many communities (Senn, Scott-Sheldon, Seward, Wright, & Carey, 2011; Singer et al., 2006). Drawing on the structural factors discussed above, numerous contextual factors (e.g., poverty, discrimination, high incarceration rates) contribute to a social and economic environment that encourages such concurrent sexual partnerships.

Research contextualizing heterosexual relationships among African Americans has also explored gender-based power. Women who feel they have more power or share power with their male partners are more likely to feel control in sexual health decision making, including the use of condoms (Harvey & Bird, 2004; Harvey, Bird, Galavotti, Duncan, &

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Greenberg, 2002). Similarly, Bowleg, Lucas, and Tschann (2004) reported interpersonal relationship and sexual scripts suggesting men most often control relationships and sexual activity and a perception among women of infidelity as normative. Bowleg et al. suggested these scripts "may indirectly or directly decrease African American women's condom use with primary partners, and in turn increase their HIV risk" (p. 70).

The current study employed a qualitative approach to identify the unique experiences of heterosexually active men and women in one community. Qualitative interviewing elicits the social actor's stories, accounts, and explanations of their experience and behavior. Through this process, the researcher is given access to the actor's experiential knowledge (Lindlof & Taylor, 2002). Focus groups allow researchers to utilize the *group effect* (the unique information that is only produced by group interaction) to enhance their understanding. According to Lindlof and Taylor (2002), stimulated by the ideas and experiences expressed by each other, focus group members engage in a process where "talk links to, or tumbles out of, the topics and expressions preceding it" (p. 182).

Of particular interest to the current study were the types of sexual relationships community members socially constructed and how these partner types shaped other factors related to condom use, such as general attitudes about condoms and condom negotiation. The ultimate goal of this study was to better inform the development of a computer-based tailored intervention targeting heterosexual African American clients of an STI clinic (Noar et al., 2011).

METHOD

Participants

Four focus groups were conducted as part of the formative research phase of a 3-year project that aimed to develop an intervention to promote consistent and correct condom use among heterosexually active African Americans, aged 18–44. The research site is a large, publicly funded metropolitan STI clinic in the southeastern United States, which serves a low-income, racially diverse clientele. It is the only publicly funded low cost clinic in this metropolitan area and surrounding counties, and thus has a large catchment area.

In July 2008, a trained recruiter worked in conjunction with clinic staff to recruit African Americans for the focus groups. Posters describing the focus group study were posted in the clinic and distributed to African American clinic patients approximately one week before the study took place. In order to extend the reach of recruitment, clients were encouraged to share this opportunity with other individuals in the community they thought might be interested in participating. The posters listed a phone number to call in order to be screened for eligibility and possibly enrolled in the focus groups. Individuals who called were screened using the inclusion criteria listed below and, if eligible, were enrolled in the focus groups and asked for their first name and phone number (for purposes of a reminder call the night before the focus groups). In addition, the trained recruiter spent the two days before the focus groups recruiting clinic patients from the waiting room at the clinic. In this case, the eligibility screener was done using a short form. Inclusion criteria for this study included being: (1) African American; (2) aged 18–44 years; (3) heterosexually active in the past 3 months; and (4) HIV-negative or of unknown serostatus. This recruitment method yielded 20 females and 18 males who participated in the focus groups, which were divided into two female focus groups (n = 10 in each group) and two male focus groups (n = 10 in one group and n = 8 in one group). Approximately 75% of those who had signed up through one of the recruitment methods came to the focus group discussions.

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In order to keep the focus groups entirely conversational, we did *not* give out a survey during the focus groups. Thus, we cannot report on the specific demographics of focus group participants (beyond the inclusion criteria above). However, shortly before the focus groups took place, we completed a survey research study of $N = 293$ African Americans visiting the clinic (Noar, Crosby, Benac, Snow, & Troutman, 2011). Inclusion criteria for this survey research study were identical to the focus group inclusion criteria and may demonstrate what is representative of typical clinic clients. Results indicated that heterosexually active African Americans visiting the clinic tended to be unmarried (92%), had a high school diploma/GED or less education (77%), were unemployed (54%), made less than $5,000 in the past year (49%), and received social assistance in the past 6 months (37%). Mean age was 26.93 years, median number of sex partners in the past year was 3, and 44% reported having an STI in the past 6 months. Finally, participants reported having the following types of sexual partners in the past 3 months: main partner only (48%), main and casual partner(s) (26%), and only casual sexual partner(s) (26%).

Measures

General topics upon which the research was focused served as an initial organizing framework for the findings. These topics included relationships and sexual partners, condom use and perceptions of condoms, and condom negotiation. The focus group discussion guide, which guided the discussion in each of these areas, is listed in the Appendix.

Each focus group was recorded in order to allow for later transcription, a task completed by two graduate research assistants. Employing a grounded theory approach, we analyzed themes from the information and stories shared by the focus group participants (Lindlof & Taylor, 2002). Grounded theory does not impose a theoretical framework–this approach instead allows researchers to derive substantive theory from field research. In this case, it allowed for a contextual analysis of how individuals in one African American community socially constructed their heterosexual relationships.

A systematic approach was taken in analyzing the focus group data. First, three independent coders conducted several readings of the focus group transcripts in order to identify initial themes within the set of topics examined in the focus groups (i.e., relationships and sexual partners, condom use and perceptions of condoms, and condom negotiation). Then, the three coders met to discuss both general themes and sub-categories within those themes. Consensus was established through comparison and discussion of the initial themes identified by the coders. Once a final set of agreed upon themes and sub-categories were identified, quotations were gathered from the data to provide support and examples for the themes. Before reporting results, all names were changed and replaced with arbitrary pseudonyms during transcription to protect the participants' anonymity.

Procedure

When individuals arrived at the clinic for the focus groups, they were directed to a private room where the focus groups took place. Trained African American female researchers obtained informed consent from each participant before the focus groups began. These researchers had extensive previous focus group experience and training, which they applied to this context to ensure groups ran smoothly and all voices and points of view were heard. The facilitators then moderated the focus groups, with each discussion lasting approximately 90 minutes. Participants were provided lunch and paid $40 for their participation. The Institutional Review Board at the University of Kentucky approved all research procedures used in this study.

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RESULTS

Partners and Relationships

The discussion guide focused on partners and relationships as one primary area. We identified three dominant themes in this area: partner type, types of sex with partners, and using condoms with certain partners.

Partner Type—Female and male participants described the following three types of sexual relationships in their community: One-night stand, "regular" casual, and main. Interestingly, in this sample, two types of casual partners emerged–"one-night stands" and "regular casual" partners. When asked about casual partners, Patti informed us "It can be somebody they know, or somebody they barely know. They might just like them." Participants agreed that someone you barely know (a stranger or brief acquaintance) is referred to as a *one-night stand*. As the name suggests, sex occurs once with this partner and there is no expectation of an ongoing relationship, sexual or otherwise. Participants spent the least amount of time discussing one-night stands, but it was apparent from the conversations that sex with this partner type was considered a different encounter than sex with regular casual partners.

Relationships with *regular casual partners* (the people you know) were discussed extensively. Both female and male participants often referred to these partners as "friend, friend with benefits, buddy or cut buddy." Individuals typically engaged in sex on a semi-regular basis with these partners. As Tina told us, "You always got that one person you can call. The maintenance man."

Interactions with many regular casual partners were primarily devoted to sexual activity. According to Patti,

> We don't want no relationship with these people. We just want the sex. We might not have a boyfriend. You know. And that's the person we are comfortable with, and we might just like that person a lot and just don't have nobody and got to fulfill our own needs. Kinda selfish, but that's how it works.

Patti's statement highlighted the idea that relationships with regular casual partners were often solely about the act of sex, but for some women it was important to have a certain level of comfort with this type of partner. Just what that level of comfort was depended on the female. "If I do have casual, it's gonna be with somebody that I've known for a long time," explained Jessica. "That's it." For women like Jessica, regular casual partners needed to be someone they knew and for some women these partners were considered friends. For example, Linda has had a regular casual partner for four years who she considers a friend but with whom she does not want to have a serious or committed relationship with: "He does things for me outside of just sex. We're friends, but I don't want that relationship with him."

Male participants also elaborated on regular casual partners. Like the women, men described sex with regular casual partners as occurring on a semi-regular basis. In addition to the terms previously mentioned (i.e., "friend," "cut buddy"), men also referred to regular casual partners as "bitch, ho, and jump off." Participants described these casual sex partners as individuals they went to for sex and nothing more. As John told us, when there were problems with his main partner:

> I'm gonna go have a little jump off. I know I'm throwin' hard. She know I live with my girl. She know what I'm on my way for. So when I get there, ain't a whole lot of rap at the door. We at it. That's a jump off.

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Paul, who remarked "…you got your wifey [long-term female main partner to whom one is not legally married] and then you have your bitch on the side," echoed this concept of men with main partners having at least one concurrent sexual partner.

Many men reported that having some type of casual partner in addition to their primary relationship was considered the norm. "I don't care how faithful you are or none of the above. I done seen the faithful of faithful and the goodest of the goodest cheat," explained Shawn. Steffen added, "As cold blooded as it sounds, it's true." Many female participants also discussed being in concurrent relationships with their regular casual partner(s) and main partner. "I got a baby's daddy, but I got friends, too," remarked Allison. Similarly, Tara told us "I got two baby daddies and a lot of friends."

The above discussion about concurrent casual and main partners led to the examination of the unique meaning participants attach to main partners. Both men and women conceptualized *main partners* as more than just a long-standing sexual partner. The majority of participants described their main partner as someone with whom they shared a deep emotional connection.

Many participants described their main partners as the mother or father of their children. Although these individuals were often not married, they explained the bond of having a child together as something that elevated the relationship's status. Thus, many women referred to their main partners as their "baby's daddy," but men used the term "baby's momma." Women also referred to main partners as "my man, my dude, and boo."

In addition to "baby's mamma," men used terms such as "baby, lady, girl, and girlfriend" to refer to their main partners. For many men we talked to, the term "wifey" in particular represented a distinct and revered main partner. Jerrod told us, "Wifey is like somethin' that nobody can't nobody come in and disrupt." He went on to further explain, "It's almost like you all are already married, but ya'll just didn't go through the whole ritual." As Robert put it, "It is like coveted."

Although women engaging in concurrent sexual relationships with a main and casual partner(s) almost universally acknowledged their main partner was probably also engaging in outside casual sex, men were reluctant to even consider the possibility "wifey" might have multiple partners. Jerrod expressed a sense of disbelief anyone would question such a relationship: "I really know her…cause, if she's my baby girl, I already know she is thorough without a shadow of a doubt." Even though male participants continuously claimed it was impossible to completely trust any type of partner, "wifey" and "baby girl" were viewed as loyal and trustworthy partners. According to Greg, "…you know with baby girl or you know wifey, ya'll done been through thick and thin. You know ya'll like Bonnie and Clyde, you know 99, she gets the fullest of your trust…"

Overall, the information in the focus group discussions demonstrated a need to explain three distinct categories of partner types. For these participants, there was a clear difference between a one-night stand and a regular casual partner. This held true for both men and women. The distinction between these two types of casual sexual partners and main partners was also apparent. Furthermore, participants claimed concurrent sexual partnerships with main and casual partners were the norm.

The distinctions between partner types played a role in the remaining sub-themes of partners and relationships. Although we acknowledge the importance of continuing to explore the nuances of one-night stands versus regular casual relationships, the participants' discussions involving the following themes and sub-themes did not always clearly make a distinction

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between the different types of casual partners. Thus, the remaining discussion often collapses one-night stands and regular casual partners under the umbrella of casual partner.

Types of Sex with Partners—We also identified types of sex with partners as a common theme. Both female and male focus group members explained that individuals engaged in different sex acts (i.e., vaginal, anal, or oral) with different types of partners. For these participants, sex with main partners was often more intimate than sex with casual partners whether they were one-night stands or regular casual partners. In these sexual partnerships, there was a level of emotional intimacy characterized by feelings or love and/or caring. Sex with casual partners was primarily physical. Interestingly, a clear gender difference emerged in how sexual intimacy manifested in primary relationships.

Women claimed to be more open to different types of sex with main partners. Increased intimacy and/or exclusivity with main partners led to a willingness to perform oral sex and/or engage in anal sex. When asked if individuals engaged in different types of sex with different types of partners, Mary explained, "You have to teach discretion." According to Jill, oral sex was something that was limited to the level of intimacy and exclusivity she experienced with her "baby's daddy." She went on to explain "You probably do things for him that you don't do for anybody else."

Female participants were also clear that anal sex was almost always limited to close and intimate relationships. "One thing I feel about anal sex, it's not tried out casually," remarked Lisa. "I feel like you have to do that with someone who you're committed to, who's willing to be patient and know your body and knows what they're doing with you."

Although the majority of women told us they were more likely to experiment sexually with main partners, some women explained they have felt the necessary level of intimacy with certain regular casual partners to try different things. "For me, and I think anyone else who has multiple partners, you have those that you trust," explained Linda. "You might say, ok, we can experiment and we can see what we gonna do and this and that, and there's others like you know 'Oh, you're just cool for this and that's it. You ain't goin' no further." This revelation further supported the idea that intimacy was a primary factor in women being willing to experiment sexually.

Men also placed clear restrictions on oral sex. Like the women, men explained they only performed oral sex when there was a certain level of intimacy with a partner. "You just don't do it to any and everybody," said Shawn. Similarly, Jerrod told us that oral sex "is just not somethin' that after a night at the club…That is not somethin' that just first thing that a brother would do."

Male participants, however, described a different set of standards in regards to receiving oral sex. As Robert explained, "It is the first thing I want." Oral sex is at the very least something male participants will try to receive from one-night stands, regular casual, and main partners. "It's regulation," according to Greg. Male participants agreed it was important to be selective about whom they performed oral sex on, and it was certainly not something a man would consider doing with a one-night stand. Summing up this perspective, Jerrod told us "She gets no dome [oral sex] from me, but I get some from her."

It also became apparent men defined "making love" as something that only occurred in sexual partnerships where there was a high level of emotional intimacy and perceived exclusivity. According to Stan:

> You gonna go ahead and make love to wifey because you love and you care about her. It's just not just gonna go in there and give her five ten minutes. You gonna go

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> in there and give wifey thirty, forty minutes of your all. You gonna give her your all until you just can't move when you get through with her.

Stan's statement also illustrated that the men in this study were generally more concerned about sexually satisfying their main partner as opposed to women defined as casual partners.

Like Stan, the majority of men described sex with main partners as more intimate. Unlike the female participants, the men were more likely to experiment sexually with a casual partner. Thus, sexual intimacy limited the sexual requests and demands the men placed on their main partner. Sexual experimentation (i.e., rough sex, anal sex, etc.) was relegated to casual relationships. For example, David explained, "You flip her over. You gonna hold her upside down. You know at home with the wifey you can't do all that."

Using condoms based on partner type—The use of condoms based on partner type was a final common theme in the discussions about partners and relationships. Participants agreed condoms were used at the beginning of relationships and with casual partners, but they were not used in long-standing relationships with main partners.

Carrie: …in the beginning, it's always a condom being used. Nine times out of ten in the beginning we always use condoms but once you get into that relationship…

Lisa: You together and you comfortable.

Male participants agreed they were much more likely to use a condom with a casual partner. For Greg, using condoms with casual partners protected his life with his partner, the mother of his child: "…you don't want no outside babies ruining your happy home. Then you don't want to bring no disease to your home."

General Condom Perceptions

The discussion guide also focused on general condom perceptions as a major area. Within this category we identified condom pros and cons, partner risk, and intention versus action as common themes.

Condom Pros and Cons—Male and female participants agreed reduced risk of pregnancy and STIs was the major pro of using condoms. A gender difference, however, was uncovered in these discussions. Women tended to emphasize protection from STIs; men emphasized protection against unwanted pregnancy. For example, Sam explained, "I have kids, you know. I don't need no more so I'm strapped up." Tom also told us, "We don't want no more babies so we gonna put a rubber on off the muscle."

Unlike the male participants, women also clearly separated the cons of condom use into female and male specific categories. Many female participants explained using condoms led to irritation and/or yeast or bacterial infections. "Condoms irritate the hell out of me, but I use 'em every time," explained Claire. "A day or two after using a condom I'm going to get a yeast infection." Females also provided a list of common male complaints about condom use. According to Pam, many men claimed "it's gonna make my stuff stink." The majority of women told us men opposed using condoms because of a lack of feeling and reduced level of pleasure.

The male participants discussed condom use cons that were male centered. The overwhelming majority of participants complained about the lack of feeling. Some men also explained losing their erections were a significant con of condom use. Finally, the smell of condoms was a problem for some men. As Mike told us, "It'll give you away to your wifey when you get home if she wants to smell you when you come in."

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Partner Risk—The majority of male and female participants acknowledged it was impossible to determine a partner's risk. As Lisa succinctly remarked, "Everybody's risky." Even though participants repeatedly claimed to know partner risk was not something one can simply determine based on looks, the men and women we spoke to explained how they went about sorting partners in terms of potential risk.

For women, it was all about a man's physical appearance. According to Patti, "You just look at somebody. They tennis shoes, and see if they dirty…they nuts are sweaty, you can look at 'em and tell." Some women, however, talked about verbally communicating with their partners about STI risk. For example, Anna explained:

> …what I've been doing with certain guys I meet is I'll ask them if they will be ok going to the clinic with me getting a test done. If they have a problem with that, them I'm kinda turned off.

Male participants also claimed to judge female partners' potential risk based on physical appearance. As Greg explained, "Another thing with the condom use, a lot of time we tend to ah, avoid using them just based on the perception of how pretty or beautiful she is." Like the female participants, some men also told us using physical appearance to assess partner risk was a precarious process. For example, Karl remarked:

> …if she looks good, everybody else wants her like you do. And like a dirty, ugly chick, don't nobody want her so more than likely she probably doesn't have nothin but I think the chances are the more beautiful chick has something.

A few men also claimed to employ various physical tests on female partners to assess their risk. According to Greg, some men used the "dip and sniff test" [smelling a woman's vaginal discharge in an attempt to determine whether or not she may have an infection]. Trey told us he preferred having sex with the lights on so he can, "see what her panties look like" [inspecting vaginal discharge for color]. Some participants even claimed to utilize the earwax test. According to Tom, "If you dig your finger in your ear and then you finger a chick and then if it burns she got somethin."

Overall, male and female participants appeared conflicted between their general sexual health knowledge and the desire to employ various heuristic and folk tests to determine a casual partner's risk. As Sara explained:

> I met some people you wouldn't know they have a disease. They talk intelligent, carry themselves well. You know these diseases don't just pick out people. Anybody can get them regardless of their status, color, or whatever. You just can't tell.

Jill then went on to tell us using heuristics to determine partner risk was just like "playing Russian roulette." Although most participants agreed it was impossible to tell a sexual partners risk by appearances alone, they felt this was commonly practiced among their peers. Interestingly, participants never discussed risk factors commonly associated with high-risk heterosexual partners, such as unprotected sex with multiple partners, male partners having sex with men, or injection drug use.

Intention vs. Action—Once again, male and female participants were quite knowledgeable about the importance of using condoms consistently and correctly to protect themselves from STIs, including HIV. In fact, many participants expressed a desire to limit the spread of STIs in their community. Unfortunately, the intention to use condoms did not always lead to action. Mike summed up this common dilemma:

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> …But once you get there and you already even said you know I got a rubber in my pocket and I'm gonna use this rubber. You even said it on your way over. You probably stop at a store, done stop ask one of your homies for one. You get over there and while you over there the situation unfolds and now it's not nobody's thinkin.' Cause I don't think I'm thinkin' when I'm havin sex. I'm just doin. You know?

Participants described the use of alcohol and sexual arousal as factors contributing in the inability to act on intentions to use condoms. David explained "… heat just overpowers the reason, you know what I'm sayin'? And then next thing you know you're doin it." Stan also told us:

> … I mean everybody done did it. I don't care what none of ya'll say. Know you've been too drunk to walk. Boom, she done sit on it and you be in the mornin' like damn what did I do? Too drunk to walk. I hope she didn't give me nothin.

Condom Negotiation

The discussion guide focused on condom negotiation as a final area. Male and female participants explained clear distinctions between negotiating condom use with main as opposed to casual sexual partners.

Main Partner—Men and women alike explained negotiating condom use with main partners as extremely difficult. In fact, for many participants, this was described as impossible. Asking a main partner to use condoms would negatively affect the relationship. As Trey told us:

> There is definitely gonna be a problem. It will be like 'I'm gonna put a rubber on,' and she'll be like 'why we got to use a rubber now? We got kids' and you know 'Why you need a rubber? Who have you been messin' with?

Female participants agreed asking a main partner to begin using condoms was very difficult, especially if other forms of birth control were being used. "I'm gonna tell you, a guy right now, if you are supposed to be in a committed relationship with him, and you ask him something about a condom. Well, he's gonna ask you, 'Well, what are you doin'?" remarked Anna. Tina agreed with this position: "Na, I can't see it happening. If she is on the pill or if her tubes is tied and you are in a committed relationship, why would you use condoms? Really, why would you use condoms?"

Although the task of negotiating condom use with a main partner was daunting, male and female participants shared some techniques they would use to convince their main partners to use condoms. For example, Lisa told us you can "make it sexy. Tell him I'll put it on for ya," suggested Lisa. "You know, you put it on for him. Use you mouth and roll that sucker down." Telling a main partner condoms decreased the likelihood of unwanted pregnancy was a technique several male participants described in the discussions. Jerrod told us, even if his main partner would become upset and question his monogamy, he would stay focused and tell her "I don't want to have no more kids."

Casual Partners—Both male and female participants said negotiating condom use with casual partners was less difficult.

Lynette: Ok. Casual person, he may want to do it, you know, without the condom, but he respects the fact that…

Melanie: He ain't gonna say nothin'.

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Lynette: He ain't gonna say nothin', but he'll understand if you say bring up a condom.

Anna: He knows you are not the only one.

Most participants echoed this exchange. Males and females claimed a straightforward approach to condom negotiation was often used in casual relationships. For example, Carrie explained, "I'm up front. I say you gotta use a condom or we not doin' it." Similarly, Shana simply stated she would just say, "Put a rubber on."

A final interesting concept was identified in the discussions about condom negotiation. Many men told us the burden of negotiating condom use fell on women in casual relationships. As Tom explained, "I feel like that is a question that a girl poses. Like man, if we want to use a condom, we just put it on, there's no question to be asked." In fact, Tom went on to say "It's a female only question, really. You don't just…if you don't want to use one, then you don't like [ask] 'do you think I should use a condom?' No. That's not our type of question."

According to these men, if they wanted to use a condom they would simply put one on and they did not need to discuss this with their casual partners. Even when casual female partners were resistant to using condoms, male participants claimed they could easily handle the situation. For example, Mike told us:

> By me wantin' it on, she's gonna accept my, you know, decision and just deal with it. And when I put that rubber on, it's just I gotta throw harder. I just gotta put a little more back into it just cause you know she doesn't like the fact I got a condom on.

DISCUSSION

Results of this qualitative study provide insights into low-income African Americans' heterosexual partnerships and risk behaviors. The key findings are now discussed with reference to the major themes indentified from analysis of the focus group transcripts. Implications of these findings for future research and HIV prevention interventions are also discussed.

Partners and Relationships

The findings of this study suggest that, consistent with research on several other at-risk populations (Lescano, Vazquez, Brown, Litvin, & Pugatch, 2006; Misovich, Fisher, & Fisher, 1997; Rosengard et al., 2005), distinctions among partner types were important within African Americans' heterosexual relationships. Both men and women discussed how members of the opposite sex could be broadly categorized into different types of sexual partners–the key distinction being "main" or "casual" partners. Participants also indicated that condoms tended to be used more with casual than with main partners. Although this was consistent with previous quantitative research (Dunkle et al., 2007; Houston, Fang, Husman, & Peralta, 2007; Lansky, Thomas, & Earp, 1998; Noar, Zimmerman, & Atwood, 2004), participants in this study were given the space to share their own definitions of (and terms to describe) differing partner types. In that regard, main partners were described as those with whom one had an emotional connection, often resulting from having children with that partner (e.g., baby's momma, baby's daddy). Casual partners, on the other hand, existed mostly or entirely for sex, and were referred to by a variety of terms (e.g., "friend," "cut buddy," "jump off").

One of the most interesting findings in the current study had to do with the possibility that qualitatively different types of casual sexual partners may exist in the lives of these African

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American heterosexuals. For example, one night stands were distinguishable from other types of more "regular" casual partners, such as a "friend" or "jump off," with whom one had sex somewhat regularly. In addition, it is possible that additional casual partner types could be distinguished in future research, such as a casual partner with whom one also engages in other activities versus a casual partner who is only available for sex. Singer et al. (2006), in their study of inner city African American and Puerto Rican young adults, proposed four broad groups of partner types: Non-committed sexual relationships (e.g., booty call), sexual/monetary exchange (e.g., sugar daddy), romantic but not committed (e.g., dating), and committed/expected to be monogamous (e.g., baby's momma). While a number of our findings could fit into this useful typology, gender differences and double standards abounded in our data–making the picture more complex in many ways. For example, while men expected their main partners to be faithful, women in our study had no such illusion of faithfulness. This suggests that in many ways, partner typology, terminology, and perceptions of rules governing such relationships may vary by gender. This leads to an important conclusion: the main/casual partner distinction used in so much HIV prevention and condom use research (e.g., Lescano et al., 2006; Noar et al., 2004) is likely much more simplistic compared to how individuals actually experience these relationships in their own lives.

In fact, much previous literature on partner types has focused almost exclusively on how differences in main and casual partner perceptions influence rates of condom use (Chatterjee et al., 2006; Kapadia et al., 2007; Lansky et al., 1998; Lescano et al., 2006; Noar et al., 2004). Findings from the current study suggest several additional paths for future quantitative research, which could aim to achieve a more sophisticated understanding of partner types. First, is their a (more complex) typology of partner types that can be used to accurately describe the various types of sexual relationships among at-risk populations such as African American heterosexuals attending an STI clinic? And, does this typology vary by gender or other factors? A variety of quantiative studies could be undertaken to develop such a typology, which could seek to identify the convergence or divergence of various terms used to describe the same or similar sexual relationships. For example, Singer et al. (2006) list 11 different terms under their "non-committed sexual relationship" category (e.g., booty call, shag partner, thang thang), but is their significant empirical support for all of these, and do some terms vary by gender or other factors?

Once such a typology is better developed, studies to test hypotheses emanating from the current study could be undertaken. For example, the current study suggests that sexual behaviors, condom use, and condom negotiation strategies all varied by partner type. Quantative studies could empirically test this by examining differences in these areas across partner type, taking into account possible gender differences and double standards. For example, from the current data, we would hypothesize that women would engage in more risky sexual behaviors and less condom use with more trusted *main partners*, while being more sexually cautious with casual partners. Contrary to this, we would also hypothesize that men would engage in more risky sexual behaviors with *casual partners* (e.g., anal sex, rough sex) while still using condoms more often with such partners compared to main partners. Further, we would hypothesize that where verbal condom negotiation took place, it was the woman who initiated it, and, that negotiation strategy would vary based upon whether it was a main partner or casual partner.

General Condom Perceptions

The current study also examined and exhibited interesting findings on general condom perceptions. Although many of the perceptions of condom use shared by participants were consistent with previous literature (e.g., Eldridge & St. Lawrence, 1995), some barriers to condom use that were unique to women and men also emerged. For example, many female

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participants described physical problems that might be related to allergic reactions to latex condoms and/or condom lubricants (e.g., bacterial and yeast infections, general discomfort, and inflammation). Although this was clearly a significant problem for many women, some participants claimed to use condoms regardless of these negative side effects. If this emerges as a significant barrier to condom use in other studies, it will clearly point toward a need for better education with regard to awareness of latex allergies and polyurethane condoms. In addition, male participants claimed using condoms with casual partners could potentially expose sexual activity outside of their main partner relationship. Clearly, this barrier may lead to decreased use of condoms with casual sexual partners and it may pose a challenge for the promotion of condom use for casual sex. Ultimately, these findings suggest that future quantitative studies that examine condom attitudes consider using condom attitude scales that are specific to gender. This is important, as widely used condom attitude scales (e.g., Helweg-Larsen, & Collins, 1994; Sacco, Levine, Reed, & Thompson, 1991) have *not* been developed to be gender-specific scales.

Discussions of the positive and negative attributes of condoms also revealed a gap between intentions to use condoms and behavior. Individuals often reported having the best of intentions to use condoms with casual partners but then failing to do so “in the heat of the moment.” These findings point to the importance of prevention interventions that build self-efficacy to use condoms in challenging situations as well as components that impart safer sexual communication and negotiation skills (Edgar, Noar, & Murphy, 2008). They also point to the importance of employing different methodologies–such as daily diaries–to better understand when intentions to use condoms are and are not realized. For example, a recent daily diary study of college students found much within-person day-to-day variability in factors such as attitudes, self-efficacy, and intentions, with changes in such factors predicting condom use. The variability in these factors was partially driven by negative affect, suggesting important situational factors that may be at play (Kiene, Tennen, & Armeli, 2008).

Condom Negotiation

Finally, the current qualitative study was able to contextualize the nature of condom negotiation among participants. Findings indicated clear differences in how individuals would approach condom negotiation with main and casual partners. For example, both female and male participants stated it would be much more difficult to negotiate condom use with main as compared to casual partners. Even though multiple, concurrent sexual partnerships appeared to be the norm among many in this sample (and particularly among men), participants still described issues of fidelity and trust as problematic when negotiating condom use with main partners. These findings were consistent with previous research (Perrino, Fernández, Bowen, & Arheart, 2005, 2006; Senn et al., 2011) and suggest that special attention be given to this issue in interventions. Negotiating condom use with casual partners, on the other hand, was viewed as an easier task, but is one that will still require skills training in interventions (Edgar et al., 2008).

Interestingly, men remarked condom negotiation was a topic that really did not apply to them, in that if they wanted to use a condom they simply did so without any discussion or negotiation. This is consistent with some previous research on condom negotiation which suggests verbal negotiation tends to be a more “female” activity while nonverbal negotiation is practiced more by men (Noar & Edgar, 2008). Both future quantitative studies and future interventions should recognize that when men do desire the use of condoms, that a non-verbal negotiation style may be preferable to them (Noar, Morokoff, & Redding, 2002).

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Limitations

There were several limitations to the current study. First and foremost, the participant samples in the current study, although purposive, were samples of convenience. Thus, there is no guarantee that these samples are representative of the population from which they have been drawn, and the results of this study should thus be interpreted with caution. In addition, it is possible that if even more focus groups were conducted, that additional (and perhaps different) themes could have emerged. We note, however, that other recent qualitative (Senn et al., 2011; Singer et al., 2006) and quantitative (Noar et al., 2011) studies examining similar populations have exhibited results that are not dissimilar from those found here, giving us some confidence in these findings. Second, since we sought to keep the entire focus group experience conversational, we did not survey focus group participants. Thus, we were unable to report precisely on factors describing these samples, such as mean age. Third, female facilitators were employed for both the male and female groups. Although such facilitators had extensive training and experience, it remains possible that gender dynamics affected the responses given in the male groups. Although all indicators are that the males were very open in their discussions, this still is a possible limitation of the current study. Fourth and finally, although this study hinted at a more fine-grained typology for partner types, it did not develop one, and areas of study such as condom negotiation could not be reported on in terms of such casual partner differences.

Conclusion

The findings from this study provide both intriguing avenues for future research as well as data that can be used to inform the development of novel interventions for promoting safer sexual behaviors among heterosexual low-income African Americans. As has been discussed, future studies should further investigate some of the complexities and contradictions that are inherent in low-income African Americans' heterosexual relationships. This includes studies examining how types of partners are socially constructed and how sexual risk behaviors vary according to partner type. Also critical to future studies is an in-depth examination of how structural factors affect sexual risk behavior among this population, as such factors are becoming increasingly recognized as a driver of numerous health disparities (Adimora et al., 2009; Singer et al., 2006),. Studies that address these topics will provide invaluable knowledge that can be used to inform the development of efficacious interventions that are responsive to the cultural norms and unique needs of this at-risk population.

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Appendix

Focus Group Discussion Questions

Relationships and Sexual Behavior

- Do most people you know have a girlfriend or boyfriend? (i.e., primary partner).
  - Do some have additional casual partners too?
  - Do some only have casual partners? (no boyfriend/girlfriend)?
- By what names do people refer to their boyfriend/girlfriend? To different kinds of casual sex partners? (e.g., friends with benefits).

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- Lets talk about sex now. When you hear the word 'sex,' what do you think of?
  - What is 'sex?' How do people define 'sex?' (probe: oral, vaginal, anal).
  - What words do people use to refer to oral sex? Vaginal sex? Anal sex?
- Do people have different kinds of 'sex' with different kinds of partners? (e.g., steady versus casual).
- How does one decide whether someone is 'risky' in terms of an STD or HIV?
  - Can you tell by looking?
  - How does one decide whether or not to use a condom?
- Do people tend to use condoms with…
  - Their boyfriend/girlfriend?
  - With other kinds of sex partners?
  - Why or why not?
- Do people tend to use condoms for certain types of sex but not others?
  - Oral sex?
  - Vaginal sex?
  - Anal sex?
  - Why or why not?
- If you decide that you want to use a condom…
  - What do you say (or not say)? What do you do? Can you give me an example?
  - Does how you say it depend on the type of sex partner?
- If you want to use condoms but your partner does not want to use them:
  - What do you say (or not say)? What do you do? Can you give me an example?
  - Does how you say it depend on the type of sex partner?

Condoms & Condom Use

- What are some good things about using condoms? What are some bad things? What problems are there in using condoms? What makes it easier to use condoms? *[Moderator: encourage respondents to give you examples of scenarios.]*
- What are reasons people you know don't use condoms some of the time? *[Moderator: you may need to probe -- here are some examples: not for sale in town, sex isn't the same with them, partner doesn't want to use them]*
  - Who makes this decision?
  - When is the decision made? *(Moderator: for example --before date, during date, in the heat of the moment)*
- What are situations in which folks are most likely to use a condom?
  - What are situations in which you are least likely to use a condom? *[Moderator: probe if necessary about: alcohol/drug use, when you're*

really turned on, when you're depressed, when risk of disease or pregnancy seems low]

- Who influences you to use (or not use) condoms, and how much?
  - Sexual partner
  - Friends
  - Family
  - Others?
- Sometimes, after couples have had sex for a while – and they know the female is on the pill – they stop using condoms. How do they make that decision? How do they decide that it's now safe to stop using condoms?

Conclusion

- Is there anything else you would like to add?

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