Published in final edited form as:

Soc Sci Med. 1999 September ; 49(5): 567–580.

Two good reasons: women's and men's perspectives on dual contraceptive use

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Abstract

In the US, continued high rates of unintended pregnancy, combined with increases in heterosexual transmission of HIV to women, have sharply magnified concern about the factors leading to or barring the use of contraceptive methods to protect concurrently against both risks. This paper reports on results of focus group research among African-American women participating in a longitudinal study and African-American men who are either partners of the women or are of similar socio-economic status as their partners.

We found a high level of agreement between men and women on the issues and problems that both sexes face. People felt that regardless of a woman's use of other contraceptive methods, a condom should always be used for protection. This belief, however, differed markedly from actual practice. Although we attempted to discern the relative salience of concern about pregnancy versus STIs, we conclude that people may not separate these two concerns in their resolve to use two methods. Furthermore, they recognized the need for dual protection, but expected conflict with their partners from using condoms as a second method because of high levels of distrust regarding sexual fidelity. Thus people are caught in a bind: distrust further increases the sense of a need for dual methods, but using condoms exacerbates the problems people have with achieving trust in relationships.

Keywords

Dual contraceptive use; Condom use; Sexual relationships; STI/HIV prevention; Unintended pregnancy

Introduction and background

I've been taking pills since I was 14, but when I start out with a guy I use condoms because I don't know where he's been or what (female focus group participant).

More career-minded women, goal oriented women...they will probably suggest to their partners: "Even though I got something, it best, you know, that you protect yourself..." You know, you never do know what's up (male focus group participant).

The high rates of unintended pregnancy in the US have alarmed researchers and policy makers since the 1970s. More recently, the increased rates of sexually transmitted infections (STIs), combined with the even more recent increase in heterosexual transmission of HIV to women, have sharply magnified concern about protecting women against STIs and HIV in addition to unintended pregnancy (Stein, 1992; CDC, 1997a, 1997b). The rates of both unintended pregnancy and HIV/AIDS infection are particularly high among African-American women. Data from the 1995 National Survey of Family Growth indicate that 72% of pregnancies among African-American were unintended, compared to 43% of pregnancies for White non-Hispanic women (Henshaw, 1998). The incidence of HIV/AIDS has recently decreased in all groups except for women and in particular, African-American women, with a current incidence of 50.1 per 100,000 for African-Americans, as compared to 3.0 for Whites (Wortley and Fleming, 1997). Despite the magnitude of the problems, relatively little research has thus far been conducted on the factors leading to or barring the use of contraceptive methods to protect concurrently against both risks.

Men and women are increasingly concerned about STI/HIV and pregnancy prevention, thus potentially compelling them to use two methods of contraception to maximize protection against both. However, some of the research that has been conducted on condom use indicates that the introduction of a condom into a relationship can bring with it a host of meanings, both positive and negative, that can disrupt the flow of sexual encounters and, consequently, the relationship. There is a need for a comprehensive look at the social, cultural and economic issues that influence the use of two contraceptive methods to protect against pregnancy and against STI/HIVs, among the population most severely affected. This paper reports on the social dynamics that surround dual contraceptive use among African-American women and men.

We conducted focus groups among women participating in a longitudinal study of contraceptive choice and change and men who were either their partners or were of similar socioeconomic status as their partners. All participants in the current study were African-American and low-income at the time they enrolled in the longitudinal study. We talked to both men and women about what they think about dual contraceptive use and how they would negotiate dual method use with a sex partner. We asked participants to talk about their experiences and beliefs about what their partners think and how they behave with regard to condom and contraceptive use.

We found a high level of agreement between men and women on the issues and problems that both sexes face. In general, participants felt that regardless of a woman's use of other contraceptive methods, a condom should always be used for protection, even though this belief differed markedly from actual practice. Although we attempted to discern the relative salience of concern about pregnancy or STIs/HIV, we conclude that people may not separate these two concerns in their resolve to use two methods. The focus group participants expressed more concern about negative associations with condoms as a second method than as the single method. They were aware of the need for dual protection but expected conflict with their partner surrounding use of a second method, particularly with regard to issues of trust and sexual fidelity. Thus, a vicious cycle is generated: distrust further increases the sense of a need for dual methods, but using condoms exacerbates the problems people have in achieving trust in relationships.

Conceptualizing dual use

Because relatively little research has been published specifically on this topic, there is no standard terminology for the multipurpose use of contraception. It is possible to protect against both pregnancy and STIs/HIV by using only one method alone — most commonly

the condom — or by using two contraceptive methods. The most common combination of methods is the condom plus a female hormonal method or sterilization. We propose the term ‘dual use’ to refer to the concurrent use of two contraceptive methods for two purposes— protection against pregnancy and protection against STIs/HIV. To describe the more general practice of protection against both risks, whether by the use of condoms alone or two methods, we use the phrase ‘dual protection’. Thus, dual protection encompasses the use of condoms alone (or any other method alone that protects against STIs/HIV, e.g. female condoms, spermicides), as well as the use of two methods. In our focus group discussions, we asked both about dual use and condom use. In this paper, we focus on dual use as involving male condoms and a female method.

The fact that the male condom is the primary method of STI protection has important implications for research on dual use. First, it is a method that must be used by the man and a woman usually has less control over its use. The use of a condom usually requires a man’s cooperation, whereas female controlled methods (such as hormonal methods) do not. Women are more vulnerable when protection against either STIs/HIV or pregnancy is dependent on a male method (Stein, 1990; Rosenberg and Gollub, 1992). Second, condoms have a number of negative attributes. In this paper we conceptualize these negative attributes as sensational (e.g. reduced pleasure, skin irritation), situational (e.g. needing to have one available when needed), relational (e.g. disrupting the flow of sexual interactions) or functional (e.g. concern about breakage or slippage). In addition, condoms are associated with the stigma of STIs/HIV and this constitutes a formidable negative attribute (one that we also conceptualize as relational in nature) (Gollub and Stein, 1993; Grady et al., 1993; Gil, 1995; Hoffman and Bolton, 1996).

Past research

Although there is a large body of literature on contraceptive use and on condom use, there is little that specifically addresses dual use among US populations (Humphries and Bauman, 1994; Frank et al., 1995; Hemmat, 1995; Griffith and Koo, 1996; Stark et al., 1996; Santelli et al., 1996; Sangi-Haghpeykar et al., 1997). The literature generally falls into two camps — one that explores issues surrounding protection against STIs/HIV and the other examining prevention of unwanted pregnancy. Cates and Stones (1992) note that these two camps should engage “in cooperative efforts to improve reproductive health” (p. 127). There is clearly a need to conduct research among men and women that will help to describe more fully the heterosexual sexual encounter, so that better programs can be designed to prevent the spread of exposure to STIs/HIV as well as unintended pregnancies (Worth, 1989; Kline et al., 1992; Roper et al., 1993).

Contraceptive decision-making

A number of studies conducted over the past few decades among populations in developed and developing countries have presented models to explain contraceptive decision-making and acceptance of new methods, involving beliefs, motivations and aspirations that affect the perceived costs and benefits of pregnancy prevention and pregnancy (Marshall, 1973; Scrimshaw, 1979; Hollerbach, 1983; Tanfer et al., 1993). As Shedlin (1990) has noted, these study populations faced a very different set of constraints than are found in contemporary African-American society. First, among African-American women, risk of exposure to HIV/AIDS now constitutes a serious threat to health and well-being and second, the choice of effective contraceptive methods has dramatically changed. Research to date indicates that motivation for contraception is stronger than for STI prevention (Fleisher et al., 1994), although the spread of HIV among heterosexuals may alter this. Two recent studies have examined potential impacts of condom use for STI/HIV prevention on contraceptive

behavior (Semaan et al., 1997; CDC, 1997a, 1997b), recognizing that promotion of condom use may have the unintended result of decreasing use of other, more effective methods of contraception. Contraceptive decision-making studies demonstrate the need to conduct research among both men and women so that both male and female perspectives on contraceptive use are included in research as well as their combined perspective as a couple (Rosen and Benson, 1982; Beckman, 1983; Severy and Silver, 1993; Landry and Camelo, 1994). This is particularly important in socio-cultural contexts in which women traditionally have little authority over their own reproduction.

Duration and consistency of method use

There are many factors that influence the duration and consistent use of a single contraceptive method and even more that bear on dual method use. Access to methods, the priority that ‘at-risk’ individuals place on protection, information about the methods and satisfaction with method choice all play a part in dual method use. Furthermore, whereas women may switch from one method to another for pregnancy prevention, there is limited choice of methods for STI/HIV prevention.

In one of the few qualitative studies that include both men’s and women’s perspectives on condom use for STI prevention, Pliskin (1997) discusses how and why people avoid talking about their risks of acquiring STIs/HIV. Although her study population is different from ours¹, we observe many of the same interpersonal dynamics in our study. She observed that couples do not talk about STIs/HIV until they have reached a certain level of trust, usually after engaging in sexual activity. Thus they are taking the risk of exposure to STIs/HIV while avoiding the verbal intimacy that would be required to talk about past sexual history. For Pliskin’s research participants, social and cultural sanctions against such talk appear to be powerful enough that they will not risk violating them. Other research documents similar dynamics of embarrassment, stigma and cultural sanctions (Forrest et al., 1993; Landry and Camelo, 1994; Lever, 1995; Gifford, 1996).

Social and cultural sanctions are found world wide against couples talking about sexual histories and contraception (Kippax, 1997). US populations, which are widely thought to be subject to less stringent taboos about sex, still may not communicate on this topic until after a measure of trust has been obtained, well after sexual activity has commenced (Mays and Cochran, 1988; Magana, 1991; Wolf et al., 1993). In the US, studies have noted that condom use is inversely related to the duration of the relationship (Soskolne et al., 1991; Marin et al., 1992). A couple may experience only a limited period of condom use — after they realize that their relationship is more than a ‘one night’s stand’ and they are comfortable enough with each other to talk about condom use, but before they have reached that level of trust that allows them to discontinue condom use. Once condoms have been discontinued, it may be difficult to introduce them again (Worth, 1989). Because reintroduction of condoms in a long-term relationship may signal one partner’s infidelity or suspicion of infidelity, condom use may actually contribute to the dissolution of the relationship.

Mistrust between the sexes

Mistrust and tensions between the sexes may be particularly pronounced among economically disadvantaged populations, where resources for employment, public services and education are limited (Worth, 1989; Billingsley, 1992; Whitehead, 1997). These stresses affect the social milieu in which couples enter into sexual relationships and potentially

¹Her study is based on 124 qualitative interviews with a self-selected volunteer population of mostly white heterosexual women and gay or bisexual men, who are well-educated and infected with genital herpes.

negotiate condom use. However, some of these problems are in part ameliorated by cultural norms and traditions: flexible household membership, grandparents helping to raise children, tolerance for out-of-wedlock childbearing, sharing of tight resources within an extended family and friends network (Stack, 1974, 1996; Taylor et al., 1988; Burton, 1995). These adaptations can provide a foundation of strength for some women and men, contributing to their ability to successfully execute their plans for contraceptive use (Worth, 1989; Kline et al., 1992), while for others, an unstable and resource-limited environment contributes to the inability to consistently follow through with plans for contraception and protection from STIs/HIV.

A number of studies have pointed to women's lack of power and inequality in sexual relationships as inherently embedded in cultural and societal norms and values, as well as in context-specific situations (Handwerker, 1990; Holland et al., 1992; Gollub and Stein, 1993). These inequities prevent women from insisting on use of condoms whether for single- or dual-purpose protection. The work of Worth (1989, 1990) with substance-using women demonstrates that an examination of women's sexual relationships should include consideration of cultural, economic and political factors that underlie women's vulnerability and lack of power in negotiating condom use. However, Kline et al. (1992) found that substance-using women, or the partners of substance users, do not have as much difficulty insisting on condom use as the literature suggests.

Our review of the literature points to a host of interconnected factors that enter into a couple's decisions to use dual methods of contraception and our research provides insights into how these factors play out in the lives of men and women. However, people find it difficult to articulate their thoughts and behavioral intentions and even to reconstruct their experiences with the topic of dual use. In sexual behavior, people often do not do what they think they ought to do, what they intend to do or sometimes even what they really want to do. Individual views about contracepting behavior are influenced by the wide range of public health messages they receive and their own social and culturally relevant norms and values, tempered by individual experiences. Thus, an individual may experience internal conflict that is complicated further by potentially conflicting desires and intentions of her/his sex partner.

Furthermore, contraception and protection from STIs/HIV are subject to 'in the moment' influences such as sexual desire and embarrassment about using condoms (Gifford, 1996). At any sexual encounter, all of these influences are simultaneously at play. Responses to questions about sexual habits may be informed by what respondents intend to do, or think they should do, rather than what they actually do. For the individual making such choices and decisions, the difference between intent and action creates tension. For the researcher, the differences between intent and action are important to recognize and reconcile. Qualitative research has a long tradition of investigating questions that are not easily answered by the research subjects themselves (Bernard, 1988; Miles and Huberman, 1994) and is the approach chosen for this study.

Methods and description of sample

For this study, a series of six focus groups was conducted, four with women and two with men. Women in the focus groups were selected from the larger sample of the Longitudinal Study of Contraceptive Choice and Use Dynamics (LSCC). This panel study enrolled women in family planning and postpartum clinics in Atlanta, GA and Charlotte, NC, who were choosing Norplant implants, Depo-Provera (two recently introduced long-acting contraceptives), oral contraceptives, condoms as the only or most effective method or female sterilization. The baseline survey was conducted from July 1993 through October

1994. Two follow-up surveys were conducted with women who had *not* been sterilized, the first an average of 17 months after the baseline and the second an average of 17 months after the first follow-up.

Women selected for the focus groups had completed the second follow-up survey in the LSCC study, were ages 18 to 34 and were not currently pregnant or sterilized. Men were recruited through one of three mechanisms: (1) participants in the women's focus groups were asked either to refer a male partner or friend for participation in the men's groups or to take a postage paid postcard for a male partner or friend to complete and mail in to indicate his interest, (2) men were recruited at a local public gym by the men's group facilitators and (3) male participants were invited to bring one friend to the group (only two men did so). Men were ages 18–39 and had not had vasectomies. All focus groups were held in a public library located in an African–American community in Atlanta, easily accessed by public transportation. All participants were African–American and the focus groups were led by African–American facilitators, matched in gender with participants.

Table 1 profiles the Atlanta component of the LSCC sample at the time of the first follow-up survey. The women from whom the focus participants were drawn were young (average age of 22), African–American and low-income (two-thirds received Medicaid). Most (86%) had never been married but most (79%) were in ongoing relationships, with an average duration of nearly 3 years. About 16% had been in the relationship 6 months or less and 17% for longer than 5 years. Only 4% had had more than one sexual partner during the 3 months prior to initiation of the method obtained at the time of enrollment in the study.

Despite their relative youth, these women had had many pregnancies (mean of 2.3), of which 70% were unplanned. Half wanted to have more children. All the women had used some contraceptive method before the first follow-up survey, many of them very effective (recall that this sample was enrolled at family planning clinics and also at a postpartum clinic that routinely urges women to use birth control methods). Additionally, nearly all had used condoms. At the time of the first follow-up survey, 9% were pregnant and 13% were not using any contraceptive; the remainder were contracepting, mostly with effective methods. Some 17% were using condoms as their primary method (i.e. as their only or most effective method). Considerably more (88%) had used condoms at some time in the 17 months (on average) that had elapsed since the baseline survey.

The 30 women who participated in the focus groups were very similar to the larger Atlanta sample (see Table 1). To obtain further information about the focus group sample, we asked the participants to complete a self-administered, short questionnaire at the end of the focus group. Because we did this in both female and male groups, we were able to compare responses from the female and male perspective. (Thus the question wording differed, as seen in Table 2.) Although these data are based on small numbers of cases, they show a broad agreement between the women and men on all four items about condom behavior. The majority of women (73%) had requested a man to use a condom in the past 12 months and most of the men (58%) said they had been so asked by a woman. Most women said the man had agreed to their request; and about the same percentage of men reported they had used condoms because a woman had asked them to. A minority of women (17%) reported a man had refused to use a condom when asked and a minority (33%) of the men said they had done so. Few (10%) of the women had felt pressured *not* to use a condom. Relatively few men (25%) had felt pressured to *use* condoms.

The men reported having had more sex partners in the past 12 months than did the women. This may reflect actual behavior or may reflect either overreporting by the men or underreporting by the women. About half (40% of women, 50% of men) had ever had an

STI. Additionally, virtually all men in the past 12 months had used condoms (75% to prevent pregnancy, 83% to prevent getting an STI, 42% to prevent giving an STI and 58% as a dual method).

In summary, our focus groups were composed of low-income African–Americans, all of whom had used condoms and a large proportion of whom had used dual methods. The women had experienced many unintended pregnancies and about half the men and women had had STIs/HIV. These groups are particularly appropriate for a study of dual method use. The men and women in the groups come from a segment of the population at especially high risk of both unintended pregnancy and STIs and HIV. Although they have practiced condom use and dual method use at unusually high rates, their histories indicate little success in preventing either pregnancy or STIs. Furthermore, they live in an urban area with a high incidence of HIV/AIDS among heterosexual African–American women; many of the focus groups participants spoke of friends, acquaintances and family members infected with HIV. What we could learn about the difficulties in practicing dual protection or dual use from such a highly experienced and at-risk group would instruct us on the even greater difficulties that can be expected for other less experienced, less motivated segments of the population.

Conducting the groups

A standardized approach was used in conducting the focus groups to improve reliability and validity (Krueger, 1994, 1998). Two African–American female researchers conducted the women’s groups and two African–American male researchers conducted the men’s groups. A topic guide was used for all focus group discussions, which lasted 1–2 h and were tape-recorded. A debriefing was held after each group, or pair of groups (when two were held in close succession), to document mood, tone and group dynamics that might not be captured on tape. All notes taken during the focus groups and debriefings were entered into a database along with transcripts of tapes. These data were reviewed for main themes and issues and then coded for retrieval and analysis. The topic guide included sections covering the following:

- Contraceptive knowledge
- Attitudes about contraception/condom use, dual use
- Circumstances surrounding dual use and condom use
- Perception of opposite sex’s attitudes about condom use and dual use

The topic guide was developed to facilitate subject shifting so that the group could first respond to a question or topic by talking about normative beliefs or experiences of friends, then later focus on personal experiences. However, at all points in the discussion, participants were encouraged to speak from experience, or those of friends and family. The topic guide also included a number of scenarios addressing various combined aspects of the discussion topics, again asking participants to answer either “What would you do...” or “What would a woman/man do...”. Questions directly related to dual method use were included at the beginning, middle and end of the focus group guide, so that the topic was embedded in the entire discussion.

Focus group data

In this paper we focus on the aspects of dual use that illustrate the beliefs, concerns and issues embedded in the processes of negotiating and managing men’s and women’s expectations for sexual relationships with regard to contraceptive use. Our focus group participants shared their knowledge and attitudes about dual method use and their experience and perceptions of reactions to condom use. Their discussions of issues of trust

and infidelity contributed greatly to our understanding of the influence these factors have on the use of contraceptive methods. In the following sections, we discuss these topics using participants' comments to enhance the discussion. Focus group participants' comments are shown in italics and the gender of each commenter is noted.

Knowledge of dual use

The focus group discussion began with a section designed to elicit knowledge about contraceptive methods and dual use. In this stage of the group discussion, participants' comments reflected their awareness of societal norms and expectations for contraceptive behavior — not necessarily their own experiences or beliefs.

Moderator: In what cases would it be good to use two methods?

Just to be on the safe side. (female)

You use the pill to keep from getting pregnant and the condom to keep from getting STDs. (female)

Moderator: What do men think about women who are using one birth control method and asking them also to use condoms?

I think it's real smart. (male)

Cause she's covering her ass, as well as covering our ass. (male)

The research participants were generally quite familiar with the concept of using contraceptive methods for two purposes. In most cases, they considered that protection from unintended pregnancy and STIs/HIV is accomplished by combining two methods, although some women spoke of using condoms alone for dual purposes². In both men's and women's groups, discussions at this level included concern about method, as well as user, failure.

Nothing's 100% but abstinence. (female)

Men... may go out there and mess around. STDs are out there. At the same time [you need] extra protection. You're not knowing that this contraceptive is going to be 100%, have an extra back-up. Think about protection for yourself. (female)

Some women know [hormonal methods are] not one 100% so they will ask [to use a condom]. (male)

Status and duration of relationship

Even though participants talked about dual method use as a good practice, one that they believe in and subscribe to, they also talked openly about using dual methods inconsistently. This is consistent with the literature on duration of relationship and communication between sexes about contraceptive use (Landry and Camelo, 1994; Pliskin, 1997). Some individuals always use two methods in the early stage of a relationship and then move toward non-use of condoms as the relationship develops. Others may initiate condom use as early in the relationship as they can comfortably do so (after they realize that they are not having a one night stand, for example), but again will tend toward discontinuing use after a period of time.

For myself I always start out when I meet a person-I always stay in a long relationship-I always have my pills and I always take my pills. We start out with a condom and then after we get to know each other we both go to the clinic and get

²We did not inquire about their source of information about protection against STIs/HIV or pregnancy.

checked and then from then on we gradually move from the condom to just the birth control. That's how I've always done it. (female)

As we shall see below, trust and fear of sexual infidelity figure into the decision to use condoms consistently. However, once condom use has been discontinued, a partner may risk a negative reaction if she/he requests the main partner to use a condom.

I told him you got to start using rubbers and he looked at me like I'm crazy, after all these years we've been together. You know, a woman knows what kind of man she's got, because you can tell if your man is cheating on you. It's very obvious. (female)

Talking about sex

In the US, as in much of the world, there are wide-spread cultural proscriptions against talking openly and candidly about sex. With women-controlled contraception, such as hormonal methods, it is quite possible for a sexual relationship to be initiated, developed and continued without any conversation or partner knowledge about whether a method is being used, or why it is being used. However, a condom is usually apparent to both partners. Because it is associated with a number of negative attributes, the condom is the method that is especially problematic to discuss, particularly with a new sex partner.

Moderator: Do men and women talk about protection against STDs?

There are certain things you don't talk about with girls. (male)

You only talk about positive things in the beginning. (male)

During the early part of the group discussion, when people were speaking about normative views of contraceptive use, participants indicated that they believe dual method use is routine and that it is not something that is discussed or negotiated. In some cases they gave the impression that condom use has become almost a default option in contemporary sexual relationships. This allows people to avoid talking about sex.

Moderator: Do women ever ask a man to wear a condom?

No... It's the man's place to come forth and present the condom... (male)

I don't give no reason. I just say we're going to use them [condoms]. (female)

Positive and negative reactions to condom use

Of course, eventually, many couples do talk about method use. Focus group participants talked about the reasons men and women both dislike condoms. The most commonly given reasons are well known in the literature and in both men's and women's groups, there were numerous agreements on the commonly disliked attributes of condoms. As mentioned earlier, negative attributes may be viewed as sensational, situational, functional or relational in nature. As the discussion progressed from talk that centered on knowledge and social proscriptions surrounding condom use, to actual experiences and scenarios, both women's and men's groups acknowledged that it is common to 'slip up' and not use a condom, even when a person would normally do so. One respondent described a scenario with a combination of these negative attributes.

Some of us, you know, get a little bit intoxicated and, you know, get hot and bothered and you know, the condoms are downstairs in your wallet and you upstairs in the bedroom and you don't feel like getting up and get it, you just roll over and get into it. (male)

While all factors do influence condom use, the factors that we have conceptualized as relational in nature are of particular concern in this paper. It is clear that the suggestion of condom use can carry either a positive or negative meaning. Positive associations with a partner's decision to use condoms include a sense that the partner cares about herself/himself as well as the partner. The man who uses condoms may be thought of as showing respect for the woman and the woman who chooses to use condoms is seen as having good self-esteem.

[Men] will respect you the more. More when you know to use the condom.
(female)

Every time I would ask [if they are using anything to prevent pregnancy], the females would have a sharp sound in their voice like, "Oh, I can't believe you're asking me that. Nobody else has. You care enough about us to want to know about children". Most of them dig it. (male)

However, there may likely be a negative response when a partner decides or requests to use condoms, particularly if the woman is using another method for protection against pregnancy. A man or a woman may perceive the condom request as an indication that their partner has other sex partners, or that the partner assumes that one or both of them have multiple sex partners. When we specifically asked participants to discuss a partner's likely reaction to a request to use condoms in addition to another contraceptive method, the responses were clearly negative.

He'll probably be like, who else have you been with, you've got someone else —
He'll think you've been messing around. (female)

But like you ask your man or your husband to wear a condom, first thing on his mind is you must think I'm cheating, or who you been with, or you telling me something, should you be telling me something that I should be knowing? (female)

When both partners are aware of the woman's use of a contraceptive method other than condoms, dual method use appears more problematic than use of condoms as a single method offering dual protection. However, in a relationship in which contraception has not yet been discussed, dual method use may occur without the knowledge of the male partner.

Successful condom use

It is fairly easy to sort out the types of reasons participants gave for using or not using condoms; however, the ways in which they accomplish condom use are much less clear. Here we discern tension between normative values and actual experiences. Participants could clearly state that condoms should be used, but their discussion of how to talk about it was less convincing. In many cases, focus group members challenged each other when someone tried to describe a condom negotiation scenario, giving any number of sensational, situational, or relational reasons as to why the negotiation being described would not work.

A: You've got to know how to play with him, sit him down and say, like, "I know you're not ready for children, I'm not ready for children, so the best thing is we use a condom and he says well"...I just talk to him. (female)

B: That's not how to talk to a man when he wants some [sex]. (second female)
[group laughter and agreement]

It is perhaps misleading to conceptualize condom and contraceptive use as being negotiated. The concept of negotiation implies that couples in some way discuss their options, perhaps state their preferences for one or another method and then reach a mutually agreed upon method. Our research confirms the findings of other studies (Kline et al., 1992; Landry and

Camelo, 1994; Pliskin, 1997) that such discussions do not usually take place, or at least not at the early stages of a relationship. Rather, one partner who feels strongly about a method may simply insist on its use. Both men and women provided examples of non-negotiated condom use.

M: Most of them just ask me to put on a condom on top of whatever they were doing. (male)

Moderator: So, have you all had that experience?

N: It's pretty much the first response. I mean, it's pretty much automatic. (male)

This is my life. There's no asking him, I'm telling him. (female)

Some of the most compelling reasons for condom use provided by the focus group participants are those we consider to be pragmatic and are associated with an individual's personal goals. Research has shown that attitudes about condom use are changing (Kline et al., 1992) and as the stigma previously associated with condom use decreases, personal goals that are seen as incompatible with pregnancy or contracting an STI may become powerful enough motivators to ensure consistent condom use.

It's been my experience that I had several women mention condoms before I did. Most of them tended to be more goal oriented and they knew that children out of wedlock would not be a good thing, you know. They would ask me to use something. (male)

Cause, today, my life and my goals and everything I'm doing and going for is, is more important than just having, just ejaculation. (male)

Even though they may have resolved to use condoms, focus group participants talked about the practical difficulties individuals encounter with condom use. Their discussion reflected differences between the ideal and real, as well as changes in the nature of relationships as they develop. In particular, participants' stories changed as they shifted from normative responses to discussions based on real life experiences or realistic scenarios provided by the moderator. At this point in the focus groups, we began to hear more clearly about mistrust.

Gender tensions and mistrust

Focus group participants spoke about trust as constituting a paramount concern within sexual relationships. Comments about trust and mistrust occurred with greater frequency than any other comments made in all of the focus groups. Participants, including those who had been together for a number of years, indicated they had very little trust in their sex partners. Although trust is important for a number of reasons in female-male relationships, the lack of trust mentioned in our groups most commonly concerned sexual fidelity. Participants spoke openly about both sexes being unfaithful. Even though women evoked marital fidelity as the ideal, they spoke as if it is seldom achieved.

When it comes to a husband that's a different thing than with the boyfriends, because you think, you THINK, you're hoping and praying that he's not doing that. But you might say well yeah I trust him to a certain point... but I don't know... you're thinking that your man won't do that to you but what you're thinking can always be wrong so you just have to have that watchful eye. (female)

You can know that person for 10 years 12 years, whatever, but you can't really say. Well, everybody can say they trust but in the back of their mind, you know... (female)

When specifically asked, focus group respondents found it difficult to talk about the relative salience of concern for STIs/HIV and pregnancy prevention. Issues of mistrust influenced both concerns. For example, if a woman believed she could not count on a man to be monogamous, she likewise believed she could not count on having a stable long-term relationship. This, in turn, influences women's decisions to put themselves at risk of pregnancy.

If she doesn't trust him, why would she want to bring another life into this world by a man that she doesn't trust. (female)

... if you've been in a relationship and you've established trust, I'm talking about years, I'd be thinking about getting pregnant. I would be thinking about STDs, but in a relationship like that, the STD thing would be out of your mind. You'd be thinking about being pregnant. (female)

Focus group participants anticipated that a request to use condoms as an additional method would result in a negative response from their sex partners. They also spoke openly of their fears about getting STIs from their regular sex partner. The woman above who said that she would 'hope and pray' that her husband would not bring any STIs home hints at a willingness to tolerate some risk of exposure in long-term relationships, in part because taking such risks is necessary to build trust. In other words, a person might be more willing to accept the risk of exposure than the risk of hurting the relationship by insisting on condom use. The willingness of a woman to accept some risk is additionally motivated by her desire for conception. Unfortunately, there is no method that will protect her from STIs/HIV, while allowing her to become pregnant.

Like myself, I've been with the same guy for 3 years and I use the pill, that's the only kind of birth control I use. If something happened I don't know what I'd do. Now as far as getting pregnant, I want to get pregnant, but I'm hoping I don't get STDs. I don't know what he does on the outside, I hope nothing, but I don't do anything [have sex with others]. (female)

Trust appears to be a rare and highly valued attribute in the sexual relationships of our focus group participants. Those participants who thought they had achieved a level of trust were still uncertain how long it might be maintained and those who had lost trust expressed a loss of something extraordinarily valuable.

I was with this guy one time, we'd moved in together and I thought I was his pride and joy and I got a call one day at work from the health department telling me to come to the clinic and I thought, health department, what have I got, we'd been together for five years. I couldn't believe it. I trusted him. (female)

Yeah. Once the trust is gone, that relationship is basically over. (male)

Men and women spoke of the difficulty of introducing condoms within this context of mistrust, especially in an ongoing relationship. This could potentially undermine the hard-won trust that is so highly valued.

If you've been with a person for a long period of time and you just all of a sudden start using a condom, it would be hard because he will think something is going on, that will be trust that he'll lose for you. (female)

Discussion

The above discussions clearly demonstrate the difficulties people face both internally and interpersonally in deciding to use dual methods. However, the research participants also spoke emphatically about the importance of using dual methods. The concept of dual use

was not a novel idea to the groups and their general knowledge about contraceptive methods and STI prevention was good. Furthermore, their experiences with STIs/HIV and unintended pregnancies, either personally or through friends or family members, provided convincing personal examples of the impact of risky sexual behavior. People knew how to protect themselves against both risks.

One of the primary problems in actually using dual protection lies in the distrust between men and women. If they do not trust each other, it is not surprising that they do not talk to each other about such an intimate topic as contraception and protection against STIs/HIV. Without open and truthful communication, people are left to their own complicated devices to make decisions about dual use. As Gil (1995), p. 198) states: "Choosing or acquiescing to a specific sexual outcome is conceived to include, among other things, a woman's (a) perception of personal autonomy in making sexual decisions, (b) evaluation of alternative sexual-behavioral scenarios, their rewards and costs to the relationship, (c) an assessment of a partner's sexual preferences and expectations and (d) a perception/acknowledgment of one's own HIV/AIDS risk". Our focus group data confirm that these processes occur with men as well as with women.

Both women and men seem to have little confidence in their partners' sexual fidelity. This lack of confidence, whether or not it is justified, may motivate both men and women to use dual methods. Still, the disincentives to use condoms in addition to other contraceptives are significant, for the introduction of a condom is an acknowledgment of the possibility of sexual infidelity or past 'unsafe' behavior. Although a couple who uses dual methods may be seen as showing respect for each other, both partners may consider that such a show of respect is necessary in only one of two cases — either one of them has an STI/HIV or one of them has multiple sex partners. Thus, unless they have discussed the fact that one partner has an STI/HIV, the use of condoms is necessarily suspect.

The real or perceived instability of sexual relationships may result in both men's and women's inability to disassociate the risks of STIs/HIV and pregnancy, for the salience of concern about either risk may fluctuate with the tenor of the relationship. An individual may have either a positive or a negative reaction to an unintended pregnancy, depending in part on the partner's reaction, perceptions of the partner's potential commitment to childrearing and/or to a long-term relationship, as well as experiences with or concerns about sexual fidelity. Similarly, we have observed that couples may not use condoms at two points in a relationship: at the very beginning of sexual relations and later, after they have achieved a level of trust in the relationship and are less concerned about exposure to STIs/HIV than an unwanted or unintended pregnancy. At this point, they may have more confidence in hormonal contraceptives and discontinue condom use. From then on, they accept some measure of risk of exposure to STIs/HIV, if they or their partners are unfaithful.

The normalization of condom use in new sexual relationships may eventually become a reality with the spread of HIV and STIs. If so, it may be related to the asymptomatic nature of some STIs as well as the potentially long period of incubation for HIV. Focus group participants noted that someone may have an STI and not know it, therefore making her/him less culpable for exposing others. Even though a person may love someone and trust someone, participants acknowledged that almost everyone has a past sexual history and with or without a visit to the clinic, no one can be certain of her/his risk to exposure. Therefore, the participants consider it sensible to always use a condom.

Dual method use, as conceptualized in this paper, is potentially quite problematic for men and women, regardless of their level of risk of STIs/HIV. This research adds to the emergent literature which suggests that dual methods are used for very few sexual couplings and are

not used consistently over the life of the relationship. Over time, if condom use becomes more routine, or other effective STI preventive methods increase in popularity, dual use could become a standard practice. However, in the current climate of heterosexual transmission of HIV, rising rates of other STIs and high rates of unintended pregnancy, dual method use warrants careful study. It is important for qualitative studies to describe the contextual issues surrounding dual use, so that larger mixed method studies can provide the research base needed to inform policy development on the topic. Policies intended to promote STI prevention as well as to reduce unintended pregnancy will both benefit from research findings on dual use.

Acknowledgments

The LSCC study, of which this research is a part, is supported by the National Institute for Child Health and Human Development. The LSCC survey is additionally supported by the Henry J. Kaiser Family Foundation. The authors wish to thank Vena Crichlow-Scales, Amri Johnson, John Warrington, Marianne Nennstiel and Michele Shedlin for their assistance in conducting this research and their review of earlier drafts of this paper.

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Table 1

Characteristics of LSCC Atlanta first follow-up respondents

Characteristic	Atlanta sample ^a (unweighted <i>N</i> =976) ^b	Focus group participants (unweighted <i>N</i> =30)
<i>Age:</i>		
Mean age at time of follow-up	22.1	22.3
<i>Race:</i>		
% African-American	96.7	100.0
<i>Educational Level:</i>		
% With high school degree	53.2	55.6
<i>Medicaid:</i>		
% With Medicaid at follow-up	64.6	58.1
<i>Relationships:</i>		
% Never married	85.5	83.6
% Currently married	8.7	14.0
% Currently in relationship	78.7	66.5
Mean length of current relationship (years)	2.9	3.3
% ≤6 months	15.9	15.1
% >5 years	17.4	27.5
% With multiple partners in last 3 months of baseline method use	3.6	7.3
<i>Fertility history/plans:</i>		
Mean number of pregnancies	2.3	2.0
Mean number of unplanned pregnancies	1.6	1.4
Mean number of live births	1.5	1.5
Mean number of abortions	0.4	0.4
% Want another child	50.6	49.7
<i>Past contraceptive experience</i>		
% Ever used Norplant	22.5	31.4
% Ever used Depo-Provera	45.2	56.2
% Ever used pill	88.6	81.5
% Ever used condoms	97.0	100.0
% Ever used female condoms	2.6	0.0
% Ever used any other methods	65.0	67.0
<i>Contraceptive status (primary method only) at FU1 interview</i>		
% Using Norplant	10.2	17.5
% Using Depo-Provera	24.9	19.5
% Using pill	20.5	21.4
% Using other effective methods	3.5	0.0
% Using condoms	17.3	11.9
% Using less effective/coitus-dependent methods	1.5	5.6
% Pregnant	9.1	9.8
% Non-use	13.0	14.3

Characteristic	Atlanta sample ^a (unweighted <i>N</i> =976) ^b	Focus group participants (unweighted <i>N</i> =30)
<i>Condom use</i>		
% used condoms at any time since baseline interview	87.7	85.3
<i>Condom use during most recent hormonal method use</i>		
% Never	19.5	15.5
% Rarely	14.3	3.5
% Sometimes	30.8	22.9
% Always	35.4	58.2
<i>Perceived HIV risk^c</i>		
% Very strong	5.0	8.7
% Strong	6.9	12.5
% Some	25.2	25.4
% Not much	36.2	36.4
% None	26.3	17.0

^a Column one shows the characteristics for *all* Atlanta first follow-up survey respondents, including all focus group participants.

^b The percentages are based on data that have been weighted to take into account unequal probabilities of selection at baseline and sample attrition from baseline to first follow-up.

^c In response to the question, "What would you say are the chances that you could become infected with HIV, the virus that causes AIDS? Would you say that you have a very strong chance, a strong chance, some chance, not much chance, or no chance at all?"

Table 2

Focus group participants responses to short questionnaire

Question topic	Women's groups	Men's groups
Requested condom use last 12 months	73% asked man to use condom	58% were asked by woman to use condom
Positive response to woman's request to use condoms	80% had man agree to use condom were asked	83% used condom because woman asked
Negative response to woman's request to use condoms request last 12 months	17% had man refuse to use condom when asked	33% refused to use condom when woman asked
Felt pressured about condom use last 12 months	10% felt pressure to not use condoms	25% felt pressured to use condoms
No. sex partners last 12 months	none: 10%, 1: 77%, 2-4: 13%, 5 or more: 0%	none: 17%, 1: 17%, 2-4: 33%, 5 or more: 33%
Ever had STI	40%	50%