Condom Use and Concurrent Partnering among Heterosexually Active, African American Men: A Qualitative Report

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ABSTRACT *African Americans are overrepresented among heterosexual cases of HIV/AIDS in the USA. Inconsistent condom use and concurrent partnering are two sexual behaviors driving the heterosexual HIV epidemic in the African American community. To inform the development of an HIV prevention behavioral intervention to decrease concurrent partnering and increase condom use among African American heterosexual men, we conducted formative research, including 61 structured interviews, 5 focus groups with 25 men, and 30 in-depth qualitative interviews between July and December 2009. We used a grounded theoretical approach and categorizing strategies to code and analyze the qualitative data. Results around condom use confirmed earlier findings among heterosexual men in general: condoms diminish pleasure, interfere with erection, and symbolize infidelity. Although valued by some as a form of disease prevention and pregnancy prevention, condoms are often used only with specific types of female partners, such as new or casual partners, or due to visual risk assessment. Sex partner concurrency was described as normative and ascribed to men's "natural" desire to engage in a variety of sexual activities or their high sex drive, with little recognition of the role it plays in the heterosexual HIV epidemic. Fatherhood emerged among many men as a crucial life event and compelling motivation for reducing sexual risk behavior. Based on these results, we conclude that existing HIV prevention efforts to improve attitudes towards and motivate use of condoms either have not reached or have not been successful with African American heterosexual men. In designing behavioral interventions to decrease concurrent partnering and increase condom use, addressing negative attitudes towards condoms and partner risk assessment is critical, as is integrating novel motivational approaches related to identity as fathers and men in the African American community.*

KEYWORDS *HIV/AIDS, Sexual risk behavior, African Americans, Heterosexual men*

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INTRODUCTION

HIV is a major public health problem in the USA today. Heterosexually transmitted HIV constituted the second highest mode of HIV acquisition, at 34 %, in 2009.¹ The distribution of heterosexually transmitted HIV is not even by race/ethnicity. Between 2005 and 2008, African Americans made up of two thirds of all heterosexually acquired HIV/AIDS cases.² Among African American men diagnosed with HIV in 2009, 20 % of the cases was heterosexually acquired.¹ In New York City (NYC), the metropolitan area with the largest number of HIV/AIDS cases in the USA, 51 % of heterosexually acquired HIV cases was among African American men in 2009,³ who make up about 22 % of city's population.⁴ Reducing the spread of HIV among African American heterosexual men in New York City is a primary public health goal.⁵

Two sexual behaviors are driving the heterosexual HIV epidemic propagation in the USA: unprotected vaginal or anal sex^{6,7} and concurrent partnering.^{8–10} Several factors have been found to reduce consistent condom use among heterosexual men regardless of race/ethnicity, including reduced sexual pleasure and concerns about sexual performance,^{11–13} negative outcome expectancies,^{14,15} condom use self-efficacy,^{16–19} attitudes towards condoms,^{13,17,19} and risk perceptions.^{20–22} Condom use also varies by partnership type,²³ relationship duration,^{24,25} use of other contraceptive methods,^{26,27} and sexual communication,^{28–31} as well as drug and alcohol use.^{32–35} Some qualitative research reports that condoms symbolize infidelity, disease status, and mistrust, which acts as a barrier to continued condom use in long-term and committed relationships.^{36–40} Although condom use has not been found to explain racial disparities in HIV or STI prevalence,^{41,42} it is still a crucial behavior change goal. African Americans living in high HIV prevalence areas would have to achieve a much higher level of condom use across all partnership types to halt the heterosexual HIV epidemic and diminish racial disparities.^{43,44}

Concurrent sexual partnering, defined as engaging in sex with two or more different people within the same or overlapping time period, is crucial to epidemic propagation via sexual networks^{45–48} and has been shown to be independently associated with heterosexually transmitted HIV.⁴⁹ African American men are more likely than white men to report concurrent sexual relationships^{50,51} and thus, concurrent partnering explains, in part, why the HIV epidemic spread has been particularly accelerated among heterosexual African Americans.^{52,53} In addition to condom use, most HIV prevention interventions have focused on reducing numbers of partners and not on partner concurrency specifically, with recent reports urging such a focus.⁵⁴

Here we present results of a formative research study designed to explore using mixed methods, the personal, behavioral, and socio-structural factors that affect HIV sexual risk behavior, specifically inconsistent condom use and concurrent sexual partnering, and HIV testing among African American heterosexual men living in high HIV prevalence areas of New York City (NYC). The research included 61 men who participated in a combination of structured, quantitative interviews, focus groups, and in-depth qualitative interviews over 6 months in 2009. The results were translated into intervention modules and piloted with a group of adult, African American heterosexual men, as described by Frye et al.⁵⁵ Because of space constraints, we report results of this formative work on HIV testing in a separate report. We emphasized qualitative methods to develop a grounded understanding of condom use and concurrent partnering.

METHODS

Study Sample

Men eligible for the study sample were between 18 to 45 years old; residents of the South Bronx or Harlem; self-identified as male; understood and read English; self-identified as African American, black, Caribbean black, or multiethnic black; self-reported HIV-negative or unknown HIV status; reported vaginal or anal sex with only women in the past 3 months; and were willing and able to provide informed consent. We recruited men into two risk categories: higher and lower risk. Higher risk (HR) men self-reported unprotected vaginal or anal intercourse with 2 or more female partners in the past 3 months; lower risk (LR) men self-reported unprotected vaginal or anal intercourse with only 1 female partner or 100 % protected vaginal or anal sex with no more than 2 female partners in the past 3 months. If a man reported 100 % protected sex with more than two partners, he was considered higher risk. We purposively sampled by risk level to examine differences in the data by risk level. Men who reported oral or anal sex with a man in the past 5 years, identified as an injection drug user in the last 3 years, or participated in any HIV or substance use prevention studies in the previous 6 months were ineligible to participate.

Procedures

Between July and December of 2009, men in the two focal neighborhoods were recruited using street recruitment methods; trained recruiters intercepted men and presented a brief (1–2 min) description of the study. Men were either given a card with a brief study description and study site contact information or, if possible, recruiters collected limited contact information (e.g., first and last name, phone number) as to contact and screen potential participants by telephone. Eligible men were invited to participate in a structured interview, the Brief Risk Assessment (BRA), and either a focus group or an in-depth qualitative interview, or both. All interviews were all conducted at The New York Blood Center research site in South Bronx. All participants read (or had read to them) an informed consent form. The BRA was a 20-min Audio Computer-Assisted Self Interview (ACASI) survey of self-reported demographic factors, sexual risk behaviors, and other factors related to HIV risk behaviors. Focus groups and the in-depths interview each lasted between 90 and 120 min. Participants were reimbursed \$15 for the BRA, \$30 for the interview, and \$30 for the focus group; they also received a two-way MetroCard for transportation costs. Referrals for resources and services were made available after the interviews and groups by the study site staff. Institutional Review Board approvals were obtained from the New York Blood Center, New York Academy of Medicine, and the Centers for Disease Control and Prevention.

Focus Groups and In-depth Interviews: Theoretical Basis and Content

The overarching theoretical approach to the formative research was the triadic model of reciprocal causality that forms the cornerstone of Bandura's Social Cognitive Theory (SCT).^{56,57} In SCT, critical determinants of health and human behavior fall within three domains: personal, behavioral, and socio-structural. Personal factors include self-efficacy, cognitions, and outcome expectancies. The primary goals of the focus groups were to explore the cultural norms (socio-

structural domain) around sexual relationships and behaviors (behavioral domain) among African American men, and perspectives on feasible interventions to change sexual risk behaviors. Two sets of groups were convened 4 months apart, with findings from the first set of groups and the intervening in-depth interviews informing subsequent groups. The first set of focus groups focused primarily on normative sexual behaviors and intimate relationships; the second set primarily explored ideas for intervention content and approaches (Table 1). A written guide, with prompts, was used by group facilitators; facilitator training consisted of presenting and discussing the study goals, preparing for the groups, managing group dynamics, as well as independent reading on the issues of condom use and sexual partnering among African Americans. Two African American male study team members, one acting as a moderator and the other as a note taker, facilitated all focus groups. During one focus group, the study project director, a female African American, was present as an observer and her presence was noted by participants, suggesting that they may have been made self-conscious by her presence. After this, only male team members were present in groups. During the groups, ground rules for participation were established and the importance and limits of confidentiality were stressed.

The goal of the in-depth interviews was to elicit “thick descriptions”⁵⁸ of the experiences of, perceptions of, feelings about, and cognitions around the focal behavioral outcomes. The interview guide delineated domains of interest, informed by SCT, beginning with the socio-structural domain and moving to a behavioral domain. Within the socio-structural domain, we first gathered background information to ground the interview in the life history of the participant and to connect that history to the community within which it is embedded. We then elicited accounts and descriptions that illuminate connections among socio-structural, personal, and behavioral domains, including the focal outcomes. Although the questions were based on the guide, we did not attempt to get detailed information on each domain from every participant, but rather focused on domains that emerged as most salient to individual participants. Interviewer training covered the same areas as the focus groups, as well as information on how to guide the interviews, explore difficult and challenging topics, and improvise and respond during interviews. Both interviewers were African American men with in-depth knowledge of HIV prevention, socio-cultural issues, and health among African American men.

Analysis

We used PASW Statistics 18, Release Version 18.0.0 (PASW/SPSS 18.0 Chicago, IL), to describe the study sample. Both the focus groups and in-depth interviews were audio taped and transcribed verbatim by a professional transcription service. All

TABLE 1 Focus group participants, Straight Talk Study, New York City, 2009

Focus group no.	No. of participants	Risk level	Focus group content
1	6	Low	Sexual behavior
2	9	High	Sexual behavior
3	5	High	Sexual behavior and intervention content and approaches
4	6	Mixed	Intervention content and approaches
5	8	High	Intervention content and approaches

focus group transcripts were reviewed for accuracy and corrected if warranted; a selection of in-depth interview transcripts was reviewed as well. Analysis of the focus groups was thematic, identifying dominant and emergent themes, attending to the men's engagement in a theme or discussion and the group's enthusiasm for emergent themes. For each group, the analytic team read the transcript and created digests that summarized the group interview content as described. For the qualitative in-depth interviews, we used a grounded theoretical approach and categorizing strategies to code and analyze the data.^{59,60} Transcripts were summarized in a "digest" that identified the major themes of the interview. Using QSR International's NVivo 9 qualitative software (QSR International Pty Ltd. Version 9, 2010), coding occurred in three steps. First, based on the summaries and transcripts, a list of analytic areas represented in the data was composed and given a code (a "closed code"). Second, the primary analyst reread the transcripts and identified blocks of text to be given a descriptive label (either a label from the closed code list or an original one, termed an "open code"). Next, the open-coded data were organized under and integrated into the closed code list. Third, the data under each behavioral outcome code (e.g., "condom use," "concurrent partnering") were read and, if needed, coded into sub-categories in order to refine the analytic categories used.⁵⁹ The first five interviews were initially coded by three analysts, who are also co-authors on the paper, and then coding was compared across the three analysts, noting any inconsistencies. The remaining interviews were coded by a single coder who was also an in-depth interviewer. In analysis, text coded as "condom use" and "concurrent partnering" were compiled, read and discussed, and analyzed by the analytic team; as relevant socio-structural and personal domains emerged, further coded text (e.g., fatherhood, race/racism, finances/economics, etc.) was read. This analytic process identified how the personal, behavioral, and socio-structural factors covered during the interviews and focus groups relate to condom use and concurrent partnering. Here we present the major, representative results, organized by behavioral outcome, i.e., condom use and concurrent partnering, as well as emergent themes within each outcome. We also conducted a contrast analysis, where text coded as either focal behavior were compared by risk level, assessing if the accounts varied markedly by risk category. As well, we specifically paid attention to data that did not confirm emerging or dominant themes, noting these in subsequent analyses.

RESULTS

Sample Characteristics

We screened 348 men, of whom 158 (45 %) were eligible as lower risk participants and 60 (17 %) were eligible as higher risk participants. The final formative sample included 61 men who engaged in a 30-minute ACASI interview. Of these 61 men, 56 unique participants completed an in-depth interview and/or a focus group. Thirty men engaged in the in-depth interviews (22 higher risk and 8 lower risk) and 34 men participated in one of 5 focus groups (25 higher risk and 9 lower risk; Table 1). Of these 56 men, the average age was 33 (SD=7.9) and all but one (98 %) were born in the USA. Just a quarter had more than a high school education and two thirds reported incomes of less than \$10,000 per year; almost two thirds was unemployed. Eighty-six percent of men reported a lifetime history of incarceration and 69 % had been incarcerated in the past 3 months. Two thirds of the men had children and of

these men, a quarter lived with their children, and 89 % supported their children. The men in the sample reported an average of 4.6 (SD=6.0) female sex partners in the past 3 months and 2.6 (SD=2.8) female partners with whom they did not use a condom; 87 % reported one or more acts of vaginal or anal sex without a condom, or both in the past 3 months. Seventy-one percent of men reported having a primary female partner in the past 3 months. Nearly all men (98 %) had been tested for HIV in their lifetimes and 82 % had been tested in the past year; 78 % reported discussing his HIV status with some or all of his partners and 69 % reported discussing his female partner's HIV status. As expected due to the selection criteria, we found that lower risk men had significantly fewer female sex partners in the past 3 months (3.1 vs. 5.3; $p<.05$) as well as fewer sex partners with whom a condom was not worn (1.4 vs. 3.1; $p<.01$), as compared with higher risk men. Although we screened men and assigned them to the lower and higher risk categories based on their self-reported sexual behavior at the time of the screening, during the ACASI interview some lower risk men reported behavior that would have placed them into the higher risk category. These men remained categorized as lower risk for the purpose of the focus groups and interviews. Lower risk men were also significantly less likely to report a lifetime history of incarceration (71 % vs. 92 %; $p<.05$); the difference in past-year incarceration was not statistically significant (58 % vs. 72 %; ns; Table 2).

Condom Use

Although a few men recognized the importance of condoms for disease prevention, the general response to condom use was negative. According to the men interviewed, condoms diminished pleasure, were only used with certain types of women/sex partners, communicated mistrust and infidelity to primary partners and disease status to new partners, and were inconvenient and difficult to use, particularly in the context of substance use.

Condom Use and Partner Characteristics Condoms were frequently reported as being used primarily with new, casual, or specific "types" of female partners; as well, condom use often ceased as relationships became more serious. Typically, men stopped using condoms after having had sex several times; one participant reported:

"you got to wear a condom too in the beginning, but once you start dating a woman three or four times, realistic, I don't think I'm going to wear a condom after you see that everything is all right, at least in your mind, you think everything is all right. I think the condoms are going to come off at some point, where you're going to do it without it." (#1099-LR)

When in a casual or new situation, several participants described how they used visual cues to assess whether they should use a condom or not. One man reported "You - like when you meet a person and you interact with them, you get your own idea of them. You've been to their house. You look at their house. If their house ain't so clean, you're not gonna think they're that much of a - so you just take from different things that you see and you know of this individual, and you make your perception based on what you know." (#1151-HR)

Re-introducing condoms into existing relationships or primary partnerships was expected to be received negatively according to several men interviewed. When

TABLE 2 Select sociodemographic characteristics of focus group and in-depth interview participants by risk group, Straight Talk Study, New York City, 2009

Variable	Total (<i>n</i> =56) % (<i>N</i>)	Risk group		<i>p</i> value
		High risk (<i>n</i> =39) % (<i>n</i>)	Low Risk (<i>n</i> =17) % (<i>n</i>)	
Age, years (SD)	33.07 (SD=7.89)	33.82 (SD=6.90)	31.35 (SD=9.81)	0.42
Born in US	98 % (55)	97 % (38)	100 % (17)	1.00
HS/GED or less (education)	75 % (42)	74 % (29)	76 % (13)	1.00
<\$10,000 annual income	66 % (37)	69 % (27)	59 % (10)	0.54
Currently unemployed	64 % (36)	61 % (24)	71 % (12)	0.56
Receiving public assistance	61 % (34)	64 % (25)	53 % (9)	0.43
Heterosexual (self-identification)	96 % (54)	100 % (39)	88 % (15)	0.09
Ever incarcerated	86 % (48)	92 % (36)	71 % (12)	0.047
Incarcerated in past year (<i>n</i> =48)	69 % (33)	72 % (26)	58 % (7)	0.37
Has child(ren)	66 % (37)	69 % (27)	59 % (10)	0.54
Lives with his children (<i>n</i> =37)	24 % (9)	28 % (7)	20 % (2)	1.00
Pays child support (<i>n</i> =28)	89 % (25)	95 % (19)	75 % (6)	0.19
Mean number of female sex partners, p3m (SD)	4.61 (SD=6.00)	5.28 (SD=6.87)	3.06 (SD=2.86)	0.029
Mean number of female sex partners, no condom use (<i>n</i> =48; SD)	2.60 (SD=2.82)	3.06 (SD=3.17)	1.38 (SD=0.65)	0.001
At least 1 episode of v/a sex <i>without</i> a condom (with a female partner; <i>n</i> =55)	87 % (48)	90 % (35)	81 % (13)	0.40
Primary female partner, p3m (<i>n</i> =55)	71 % (39)	67 % (26)	81 % (13)	0.34
HIV test, ever	98 % (55)	97 % (38)	100 % (17)	1.00
HIV test, past year (<i>n</i> =55)	82 % (45)	82 % (31)	82 % (14)	1.00
Discussed his HIV status with some/all partners (<i>n</i> =27)	78 % (21)	74 % (17)	100 % (4)	0.54
Discussed his partners' HIV status(es) with some/all partners (<i>n</i> =55)	69 % (38)	64 % (25)	81 % (13)	0.34

asked what his girlfriend would think if he started to wear condoms again, one participant responded:

"I mean, like any woman. 'Why? Why all of a sudden now you want to use condoms?' It would raise the question and make them think you're doing something. It'll make them, you know, want to know. Are you trying to tell me something? Are you scared? You know, women think like that. And to me it'll just make her think why all of a sudden?" (#1151-HR)

Some men described female partners who did not want to use condoms, expressing the desire to become pregnant. One man said:

“Sometimes, like, we’d be doing it and she’ll somehow get the condom off or there be times I’ll be doing it with her and I wouldn’t have a condom on and she would try to, like, stay on me so I could [cum]. I’m like, ‘Why would you do that?’ ‘I want your baby.’ ‘I’m not trying to give you a baby.’ You know, so, you know, a lot of - it’s on both sides of the fence, men and women.” (#1258-HR)

Not having more children was also reported as a potentially acceptable reason for re-introducing condoms into existing or primary relationships. One man stated, “Unless you try to tell her listen, baby, I know you really don’t want to have no kids or nothing and this is why I really want to use them. They might go for that.” (#1151-HR)

Barriers to Condom Use One important barrier to condom use was reduced sensation or loss of erection. “Sometimes there’s not really much of a different feeling but sometimes it is much of a different feeling. In that situation it was much of a different feeling. Without the condom it was like YEAH.” (#1032-HR). Some men described how condoms also contributed to loss or challenge of an erection, a serious problem for many men; one participant reported, “It’s like when I put it on the feeling goes away immediately, like I gotta work extra hard to keep an erection, just to put the condom on.” (#1021-LR) Practical barriers to condom use, like not having them handy or not having time to use them, were described by a few men, although these reasons were most salient in non-primary partnerships or casual relationships. For many men, the barrier to condom use was a lack of motivation; for example, one man reported that, “Like when it comes to women, man, ah, you know, if they wanna give it to me, I’m gonna take it - you know - whether I got a condom on or not. There’s been times I had condoms in my pocket and didn’t use it, right.” (#1123 HR).

Several men said that not using condoms was attributable to “living in the moment.” One low-risk man reported “I’ve got kids but it just - when you in the spur of the moment you just go, you’re not even thinkin’, you’re not - you’re not - really - really conscious of what you’re really doin’ you know? Just livin’ in the moment.” (#1021-LR) Afterwards, this man stated that he was “disgusted with himself” for failing to use a condom in what he assessed to be a high-risk situation. Several men described the remorse and regret they often felt after having unprotected sex with women as a motivation for using condoms. One man indicated an awareness of the risk associated with unprotected sex, with an unprotected encounter resulting in a trip to the clinic. “If I decide to, you know, have sex without using a condom, then I think man, maybe I should [have] use one, not because I ... but [I] just have a doubt, I go to the clinic.” (#1151-HR) Drug and alcohol use also negatively affected condom use, with men stating that drugs and alcohol diminished their ability to use condoms; one man reported that “Sometimes, yeah, you know, people - alcohol and drugs do play a part where you don’t want to use a condom because you don’t think about it.” (#1258-HR)

Reasons for Condom Use Some participants described reasons for using condoms, with disease prevention emerging most strongly. One man described how he warned his friends to use condoms, “I tell them, to make sure you strap up because it’s

critical out here, but all my guys, they don't play that. They don't play that road, they don't play it, they don't play that beat, they all strap up." (1030-LR) For most men, disease prevention was the primary motivation in using condoms, when they were used. Some indicated that they use condoms to protect primary partners, "I wouldn't wanna bring nothing home back to the wife if I was to cheat." (#1194-HR) One participant linked pregnancy prevention to an identity-based reason for using condoms that was notable. He stated:

"I know people that are younger than me and got a flock of kids, eight or nine kids, by nine different women. That's not cool. That's yucky. So you mean to tell me you running in everything raw. All right? [LAUGHTER] It's yucky. I ain't no - no angel or nothing. I ain't no better than nobody, but I know what I want in life. [cross talk] And eight or nine kids ain't the move." (#1035 -LR)

Similarly, fatherhood emerged as a compelling reason for a range of self-protective behavior among the men interviewed. One man stated: "The biggest thing in my life that happened was my daughter. Changed everything" (#1040-HR). Several men described their children as the primary reason for adopting and maintaining healthier lifestyles, including use of condoms. One man said, "Without them, there is no meaning. They keep me focused; they keep me level-headed; they keep me on the straight path." (#1021-LR) Some men described their motivation for condom use as wanting to stay healthy for existing children, as well as wanting to be ready for fatherhood in the future. One man described how he used condoms specifically to prevent future pregnancies, because more children would affect his ability to care for his daughter. He said, "Because I don't want no more kids. I'm good. My daughter, she going carry on that - she going carry on...If I bring another seed into this world, because it's - it's already hard as it is. You know what I mean? To have another child? It's going to be hard." (#1035-LR)

Concurrent Partnering

Reasons for Concurrent Partnering Men offered several reasons for engaging in concurrent partnering. Some men indicated that they desired or "needed" a variety of sexual relationships and to engage in various activities with different partners. One man stated, "there may be things that one female does that the other doesn't." (HR-1195) Many men described labeling female partners, using terms such as "wifey," "side chick," and "freak." These labels reflected the relationship type, as well as the sexual activity that occurred in the relationship. Related to the concept of sexual variety as a need was the idea that it was in men's "nature" to partner concurrently. One man reported, "I just have - I have a high sex drive and that's just me, that's my nature." (#1076-HR) Other men made more value-laden statements, saying "men are just hos." (#1107-HR) Others followed this theme and indicated that men who partnered concurrently "lacked discipline," particularly men who "cheated" on their wives. Some participants suggested that men cheated because it is offered and it is an "ego boost" for them. One participant reported, "It's more of an ego thing, what you know, we, we, we have to conquer the things out there, if we see [someone] that look good, we don't care, we got to claim that, we don't care if you got a man." (#1033-LR) Finally, a few men described the thrill associated with engaging in sex outside of a main relationship. One man said,

"It's exciting cause you're wearing a mask you're trying not get caught. You know, you sneak in someone else...You already know, you must have done it already a thousand times, the same way, even though you doing the same thing with someone else it's different, it's a rush because you're not, you, you're on a time schedule because you have to be back where you're going and there's a different passion I think it's just different, the feelings are different." (#1039-HR)

Some men offered accounts of concurrent partnering as a form of economic survival, as they needed support from multiple women. One man described concurrent partnering as part of his hustling "lifestyle" and a behavior crucial to survival on the streets.

"Yeah, I've done that thinking that that was slick and, you know, I'm thinking about it now and it was like - I don't know. It was - it was dealing in a situation that I was dealing in at the time so it involved my lifestyle...So it was more a thing of survival...You know what I'm saying? So I had one chick that was doing this and I had this chick doing that. So when this chick found out about this chick ...it was like - yeah. I'm like, you want me to get rid of her or you're going to take her place or you're going to do what she's doing for me." (#1032-HR)

One man described losing a woman who was his main source of support due to sex outside the relationship:

"I mess up 'cause she was taking care of me. I was hustling and she was a teacher, she was still working and she was still taking care of me, like buying me stuff, I had a chance to live with her but I wasn't too good with that" (#1174-HR)

Reasons for Not Partnering Concurrently The participants offered several reasons, however, not to engage in concurrent partnering or cheating, including that it can hurt the primary partner or destroy the relationship. Some men described the stress and financial cost associated with trying to manage multiple sexual relationships at one time. One man who described having five partners at one point reported that concurrent partnering became highly stressful, "Stress - like I'm dealing with five different personalities at one time....My pockets is getting low." (#1039-HR) Another reason to not partner concurrently was fear of disease. One man stated, "Because they know there's less diseases that way, you shouldn't be getting those disease if you're messing with one woman and she messing with one man." (#1099-LR) Several men described not wanting to partner concurrently because of identity-related impacts associated with it, specifically their identities as fathers. One man envisioned how his daughter would see him and potentially try to model his sexual behavior, if he continued to engage in such behavior. Participant: "It's not cool. You know what I mean?" Interviewer: "Yeah. Why do you think it's important for you to not show your daughter [you] with a lot of women?" Participant: "Because I don't want her to grow up and be no hood rat." (#1035-LR) Several men with children recognized that they served as models for their children and consciously managed their sexual and partnering behaviors to project a positive model. One man said, "I want to raise my daughter the way my father raised me" (#1040-HR) and another said about his son, "I am going to be a positive role model in his life." (#1192-HR)

Concurrent and Multiple Partnering as Normative The majority of men interviewed described concurrent or multiple partnering as normative and generally socially accepted. One man stated: "I don't know nobody right now that has one girl. Even my grandfather has a few females. I don't know nobody that has one girl ... I don't even know a married couple...It's crazy." (#1174-HR) One young man described concurrent partnering as typical behavior of his college peers, men from his fraternity. Some participants recognized that women were partnering concurrently or with multiple partners as well. One man stated, "That's the crazy part though.... I know this one girl got her friends and they go out and all they want to do is want to fuck other dudes. They like me and my boys but opposite, you know what I mean?" (#1041-HR) Some men distinguished having concurrent partners from "cheating," which occurred among married people, and although perhaps normative, was not socially acceptable. Men who did not engage in cheating or concurrent partnering attributed it to a unique personality characteristic; one man in discussing concurrent partnering said "like I said, I'm a good person. I know you know, we just meet and like that, but I'm a good dude. I don't play games." (#1033-LR) The men who did not endorse cheating were typically the lower risk men. Only one man explicitly identified concurrent partnering as the source of the high prevalence of HIV in specific areas explaining, "I fuck her she go and fuck somebody else. You know what I'm saying. Then she go fuck somebody else. So that's how it spreading it out so fast, because everybody sleeping with everybody. Everybody cheating. You know what I'm saying, people, everybody sleeping around with everybody." (HR Focus Group)

Differences by Risk Level in Condom Use and Concurrent Partnering

We contrasted text on both condom use and concurrent partnering by self-reported risk level. We noted that sexual behavior, particularly condom use, was fluid with lower risk men often describing periods in their lives when they did not use condoms consistently. Overall we noted that some lower risk men described the need for condom use in absolute terms, stating for example "It's a must. It's a must. Ain't no 'I'll think about' 'I'll see, give me a minute.' It's a must." (#1033-LR) Yet many lower risk men described ambivalence around using condoms, often related to sensation, as well as using them selectively depending upon partner type. Regarding concurrent partnering, lower risk men tended not to report engaging in concurrent partnering recently (as would be expected), attributing this behavior to having grown older, found the right person, or being a certain "type" of person. One man said, for example, "I was never the cheater type." He went on later to say "I am more [a] homebody" (#1035-LR). However, lower risk men confirmed that concurrent partnering was normative among their friends and family.

DISCUSSION

Inconsistent condom use remains a problem in HIV prevention, with levels of condom use too low in high prevalence communities to effectively interrupt transmission.⁶¹ The reasons offered by the African American heterosexual men interviewed for this study for not using condoms were largely consistent with the extant literature⁶²⁻⁶⁶ and suggest that existing prevention messages focused on improving attitudes towards and increasing motivation to use condoms either have not reached or have not been successful with this population. As one focus group

participant noted, "I see more advertisement for illegal drugs beers and I see more shit for other stuff and clothing than I see for AIDS." The higher risk men in our sample described little motivation to use condoms despite basic knowledge of condoms' utility in disease and pregnancy prevention. One of the most consistent reasons offered for not using condoms among this sample was loss of erection and diminished pleasure associated with condom use. This finding is also not new^{63,67,68} but suggests that skills for maintaining erection while using male condoms and promotion of the female condom are important prevention messages to communicate. The men also described familiar partner-type, situational, or drug and alcohol-related barriers to condom use, suggesting that increasing foundational knowledge and offering opportunities to practice condom use communication and skills with new and casual partners are necessary to any intervention approach designed specifically for this population. That such basic knowledge and skills training would be needed is a disheartening finding of this formative research.

One motivation for condom use that emerged strongly in our data centered around men's desire to stay healthy and remain present for their children. Several men articulated how having multiple children from different partners might be viewed negatively by their children, as well as wanting to have the time and resources to focus on existing children. These two reasons, one related to their identity as father and the other more practical, motivated several men to prioritize condom use. This suggests that prevention approaches that hinge on how men see themselves and perceive themselves to be seen by others, particularly as fathers, may be critical to motivating behavior change and sustaining that change over time. As well, the practical aspects of fatherhood provide a powerful motivation for men to engage in healthy sexual and other health behaviors. Connecting a sense of self and social identity as fathers to self-care and care for community is a potentially powerful intervention approach.

In terms of partner concurrency, the men interviewed described it as normative behavior, practiced by both men and women alike, and offered several reasons for engaging in partner concurrency.⁶⁹ The results here support Gorbach's and colleagues' concept of compensatory concurrency where different partners satisfy different sexual needs.⁷⁰⁻⁷² Accounts of the downsides of concurrency were offered, with men describing concurrency as stressful and financially difficult to maintain. Some men described concurrency as a survival tactic, highlighting a potential link between the men's lack of economic resources and their sexual risk behavior. Several assessed it to be a behavior that, similar to having many children with several different partners, could negatively affect how they are perceived by their children and community. In contrast, other men described the masculine identity enhancing aspects of concurrent partnering, suggesting that the presence of children alter definitions of manhood. That concurrent partnering had identity impacts for men suggests that offering information and raising consciousness as to the connection between concurrency and HIV in the African American community may be effective in behavior change. Because so few men recognized the role that sex partner concurrency plays in the spread of HIV among heterosexuals, HIV prevention messages and interventions should also emphasize this. Finally, as men were ambivalent about concurrency despite its stated benefits, motivational interviewing approaches that directly address decisional balance could be helpful in moving men away from concurrent partnering.

LIMITATIONS

There were several limitations that must be noted. First, the data presented here are not representative of all heterosexual African American men, only representing the perspectives of a select group of men, living in high HIV prevalence areas of a major urban area. In addition, because sexual behavior fluid, the cross sectional approach is limited and a longitudinal approach is needed to more fully capture sexual risk behavior over time. Due to space limitations, we cannot present the data linking the full range of personal, behavioral, and socio-structural factors investigated to the focal behavioral outcomes, but instead focus here on the connections that emerged most strongly and thus formed the basis for the intervention developed.

CONCLUSIONS

Several analysts have urged that novel intervention approaches be developed to interrupt HIV transmission in the African American community by focusing on the sexual network drivers of HIV spread,^{54,73} in addition to increasing condom use. Based on the study results, we suggest a renewed effort to provide basic information on HIV/AIDS and condom use to this at-risk population. Effectively promoting condom use will depend upon addressing ambivalence around condom use, attempting to shift men towards use by emphasizing the positive aspects of condom use, including disease and pregnancy prevention and identity-related outcomes, while enhancing skills to minimize the negative effects, for example diminished pleasure. Unique sources of motivation for using condoms were identified, specifically personal and social identity as a father, that may be integrated into prevention efforts to tip the balance in favor of condom use. Practical barriers to condom use in casual situations continue, thus developing strategies and teaching skills for overcoming these situational barriers is critical. The difficulty of re-introducing condoms in primary partnerships emerged strongly; thus, more complex behavioral strategies, including couples testing and counseling and negotiated safety, ought to be explored.

To our knowledge, partner concurrency has yet to be the focus of a behavioral intervention for African American heterosexual men. We found that high-risk heterosexual men are largely unaware of the role that concurrency plays in HIV and STI propagation. This indicates that basic knowledge is required to build the foundation for behavior change strategies around reducing concurrency. As with condom use, we conclude that social identity may be able to be used in discussions of concurrent partnering, as men fulfill their roles as fathers in the African American community. The impact of personal and social identity on risk behavior suggests that concurrency may be targeted most effectively through multi-level interventions that combine behavioral and community-based and structural approaches, attempting to shift social norms, and address the structures that give rise to them, as well as teach practical risk-reduction strategies. These results, in the context of a small but growing body of research on African American men's sexual experiences, offer guidance for developing much needed behavioral and structural interventions for African American heterosexual men.

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