

# **The Prevention Marketing Initiative Sacramento Demonstration Site**

## **Audience Research for HIV Prevention Planning**

*Results from focus groups and individual interviews  
with Sacramento-area adolescents and their parents*

May 1996



The research presented in this report was conducted under the direction of Dr. Neil Flynn of the University of California-Davis, Department of General Medicine, HIV Prevention Studies Group. The original research protocol was designed by Dr. Olga Grinstead of the Center for AIDS Prevention Studies (CAPS) at UC-San Francisco, and modified for the PMI Sacramento Demonstration Site by UC-Davis, with input from CAPS, the Academy for Educational Development (AED), and the Sacramento Demonstration Site staff and Steering Committee members. All recruitment, field logistics, and moderation was carried out by UC-Davis HIV Prevention Studies Group. Analysis was conducted by UC-Davis with assistance from the institutions named above; secondary analysis was carried out by the PMI Sacramento Demonstration Site staff and AED research specialists. This written report was a collaborative effort of all the participating institutions.

This research was conducted under contract from the Academy for Educational Development, with funding from the U.S. Centers for Disease Control and Prevention. For additional copies of this report, please contact:

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# **A** *few words before reading the focus group results...*

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The Prevention Marketing Initiative is pleased to present the findings from local focus group research. Please review these Questions and Answers before reading the attached report.

## **Why was the research conducted?**

This research was conducted as part of the community HIV prevention efforts carried out by local organizations involved in the Prevention Marketing Initiative (PMI). At the heart of prevention marketing is the principle that effective HIV prevention activities must be “data-driven,” that is, planning must be based on concrete epidemiological and behavioral information. This research was conducted to complement existing epidemiological and behavioral data, to assist in the planning of local HIV prevention activities for young people.

## **What’s the research about?**

The research looks at the behaviors and attitudes of young people around relationships, abstinence, sex, condom use, their future, communication with friends, partners and peers, and media use. It also involves parents and other influencers in the lives of young people. The research applies a mix of consumer marketing principles and behavioral theory to explore the behavioral determinants of risk and protective behaviors, in order to address barriers to prevention.

## **What will PMI do with the findings?**

The research findings contained in this report were used by the PMI Site Design Teams in planning local prevention activities. The findings were used in conjunction with other local and national data to identify specific target audiences and behaviors, and to develop a plan for reaching local youth with prevention activities. This “data-driven” process will allow the community to design an effective and appealing prevention plan, because like in commercial marketing, it considers the consumer perspective in the very design of the program.

## **How can you use this report?**

The local Prevention Marketing Initiative is making this report available to the public because we feel the results may be of use to others in the community. The report provides a vivid portrait of local youth and parents, highlighting their behaviors and attitudes about a myriad of topics.

## **How should you *NOT* use this report?**

The techniques used to explore these issues — focus groups and in-depth interviews — will not allow you to “generalize” the findings to any larger population. PMI is not saying this research represents all youth in your community, and neither should you. Only a statistical random sample selected systematically from a larger “universe” would allow you to make general statements about that group. In this study, participants were not selected in this way; they were selected specifically because of certain characteristics of interest, for example, sexually active 15 year olds with no history of sexually transmitted diseases. This research also tells nothing of a statistical nature — how much? how many? how often? It does provide rich detail on the “why?”, giving insight into what motivates young people to take risks and what can motivate them to protect themselves. We hope you find it interesting and useful to your work.

## **Who’s involved in conducting the research?**

*This research is being done as a collaborative effort* between local community organizations, specialists from national HIV prevention organizations, and the U.S. Centers for Disease Control and Prevention (CDC). Research activities were managed by professional researchers at the UC-Davis HIV Prevention Studies Group working hand in hand with HIV prevention partners in the community.

*Widespread community support made this research possible.* All research activities were reviewed by a local Institutional Review Board (IRB), who scrutinized all aspects of the research to assure that activities were ethical, confidential, and technically sound. Both parents and teens were advised of their rights as research participants, and both signed written consent forms allowing their participation.

*Every precaution was taken to respect the rights of teens and parents.* No names are used in any report or description of the research. Information and counseling were offered should any participant find that taking part in the study led to “distress.” None, to our knowledge, needed assistance, although we really wouldn’t know because they are able to access this information confidentially.

National research has clearly demonstrated that exposure to any realm of sex education or prevention does not hasten the onset of first intercourse nor increase intercourse frequency. (See Zelnick and Kim, 1982; Furstenberg et al, 1985; Dawson, 1986; Marsiglio and Mott, 1986; Ku et al, 1992; Kirby, 1985.)

Overall technical guidance was provided by the University of California-San Francisco Center for AIDS Prevention Studies, the Academy for Educational Development (Washington), and the U.S. Centers for Disease Control and Prevention (Atlanta).

For further information or questions, please contact Kristen Weeks-Norton at the PMI

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# C *ontents*

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# ***E***xecutive summary

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## **Introduction**

In 1993, the U.S. Centers for Disease Control and Prevention (CDC) launched a project to prevent the sexual transmission of HIV among youth age 25 and under. This project, called the Prevention Marketing Initiative (PMI), includes prevention projects in five demonstration sites across the country. Since 1994, the Sacramento site's PMI Steering Committee (the community oversight and planning body for the project) and its staff have been working through the planning steps to develop a marketing plan. In March 1994, the Council conducted an extensive situation analysis and selected a preliminary target audience for the campaign. The next step was to conduct formative research to better understand and define the audience, to target specific audience segments and at-risk behaviors.

Research data was collected through 24 focus groups and 40 individual interviews. The target group for the formative research was teens ages 14 to 18 years and parenting adults of 14-18 year olds, residing in 15 "high-risk" zip codes in Sacramento county. Twenty-one young adult focus groups, consisting of 166 participants, were conducted. Focus groups were segmented by age, gender, and sexual orientation. Three parent focus groups, consisting of 22 parents, were also conducted. Thirty individual interviews were conducted with adolescents and 10 with parents.

The research explored the major determinants of risk and protective behaviors, looking at knowledge, attitudes, beliefs, skills, and practices concerning emerging sexual behaviors. Parents were included in the research both to explore parental influences on the topics of interest, as well as to gauge parental support for community-based HIV prevention.

## **Highlights of focus group findings**

The 24 focus groups and 40 individual interviews queried a variety of behaviors and interests of teens. In general, teens were outspoken about their opinions and ideas, offering many important views and relevant information. The following are key points derived from the analysis of research findings.

### **What kids do with their time**

Teens interviewed stated that they like hanging out with friends both male and female and of a variety of ages. They like "kickin' it." Some of the activities they engage in include hanging out at malls, going to the movies, playing music, talking, working, playing sports, getting high or drunk, flirting, and having sex.

## **What's cool**

Being cool means “individuality” both within a group and outside of a group. It's doing cool things and having an attitude or a style.

## **Importance of having a relationship**

Both males and females say they are not particularly interested in having relationships. In actuality, relationships are fairly common. Behavioral norms were apparent, and varied when “in” and “out of” a relationship. The length of relationships varied widely (from weeks to years), but could be considered “serious” within a relatively short time.

## **Sexual behavior**

A checklist completed by participants indicates that 114 out of 166 teens have had sexual intercourse. Some have had one partner while others have had multiple partners. The focus group participants reported that, most often, sex isn't planned, it “just happens.” This apparent lack of planning explained unsafe behavior in the minds of respondents. Drugs and alcohol often accompanied sexual activity, and were seen to enhance the sexual experience. Teens report having sex at a variety of places, some of which include each other's houses, in parks, in cars, at school, and at fast-food restaurants.

## **Reasons to have sex**

Even though sex is of equal importance to males and females, responses indicate gender differences as to reasons for having sex. Some females report having sex to acquire love, trust, and attention. Many say they will keep having sex if it is good. Many males have sex with or without commitment and will often find someone new if sex is not good or if another willing person comes along. Gay and bisexual males reported wanting relationships for intimacy and companionship as well as for physical gratification, as did some of the females in the study.

## **Abstaining or delay**

The issue of abstinence came up more often from female participants than from males. For a few females who choose to abstain, they talked about remaining virgins as a way to meet long-term goals, that is, education, career, or marriage. For those who were sexually active in the past and now choose to abstain, they either had negative experiences or were changing their goals and attitudes. In general, many females choose to wait to have sex in a new relationship, but not for long, speaking of a delicate balance between wanting a male to respect you, getting to know the guy, and both partners wanting to have sex. Only a few males interviewed have decided not to have sex. Both males and females, whether sexually active or abstinent, respect girls who choose not to have sex. Some males, while respectful of a decision to abstain, would simultaneously go outside of an abstinent relationship for sex.

## **Condom use**

Both males and females know about condoms and the reasons they are used: to prevent pregnancy and STDs. Some respondents appeared to use condoms consistently in all situations. Those respondents often articulated a strong commitment to always using condoms. Others spoke of condom use in a highly contextual manner — using them in some situations and not in others. Many participants, both users and inconsistent users, had a litany of problems or complaints about condoms.

When the relationship continues condom use tends to decline. Trust is the key issue raised by both males and females; once they feel they “know” their partner, condom use diminishes.

Many teens know where to get condoms: at stores, clinics, from parents and from friends. Some don’t like to buy them and believe they are too expensive. Others speak of barriers that suggest incorrect use: discomfort, breaking, tearing, and so forth. There are several barriers to using a condom. They include:

- too much hassle (to put on, interrupts foreplay)
- too inconvenient to get (don’t know where to get them, too expensive, too embarrassed to purchase)
- trust/love of their partner (we don’t need them if we trust each other or have been tested)
- drug or alcohol use (they are hard to use when “wasted,” or participants “forgot” to use them when high)
- too uncomfortable (mostly for males but for females too)
- will imply person can’t be trusted; shows belief that partner may be fooling around.

Teens don’t often discuss using a condom with their partner; condoms just “appear” if one or both partners practice condom use. Discussion was thought to ruin the moment, and little discussion happened outside of the sexual context. Males and females respect those who always use condoms and think they are “smart.” Conversely, teens expressed disdain for those who would never use condoms and said they were “dumb” and “dirty.”

## **AIDS knowledge and salience**

Of the 166 focus group participants, 54 mentioned that they knew people personally who have or had AIDS. Several participants mentioned that the people they knew were more than casual acquaintances, such as uncles, boyfriends, friends, and cousins. Those who have had this experience tend to be more careful in their sexual practices. AIDS/HIV was very close to focus group participants.

Some participants felt they could have been exposed to HIV.

Many participants mentioned that through knowing someone with AIDS they were more aware of the consequences of getting AIDS and therefore practiced safer sex. For many others, the linkage between knowing someone with AIDS and adopting protective behaviors was less clear, as was the relationship between their own perceived risk and safer sex behaviors.

### **Prevention messages**

Many teens expressed that they are not impressed with current messages. Several say that messages are often vague, repetitive and not sophisticated. Many say they “talk down,” to them and are sometimes insulting. Most teens expressed that they want to know the facts, the details with “true life” people, preferably of their own age group. Many mentioned that hearing from young people with HIV and AIDS was highly effective in catching their attention and provoking thought about their personal behavior.

### **Next steps**

This information in conjunction with the other local, state, and nationwide data will be used to guide the target audience selection and prevention strategies for the Sacramento Demonstration site. A prevention intervention is expected by Summer 1996.

# ***B***ackground

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## **The Prevention Marketing Initiative**

In 1993, the U.S. Centers for Disease Control and Prevention (CDC) launched a project to prevent the sexual transmission of HIV among youth under age 25. This project, called the Prevention Marketing Initiative (PMI), includes pilot projects in five demonstration sites across the country. The Sacramento Demonstration Site is working to develop a social marketing project targeted to Sacramento youth.

Since 1994, the Sacramento site's PMI Steering Committee (a community oversight and planning body) and its staff have been working through planning steps to develop a marketing plan. In March 1994, the Council selected a preliminary target audience for the campaign. The next step was to conduct research to better understand this target audience.

The planning process developed for PMI depends on this formative research phase. A successful social marketing program studies what influences and motivates given behaviors among groups of people. This information guides the design of strategies to affect those behaviors — either to change or sustain them over time.

The CDC defined broad behavioral goals to guide PMI. These are:

- Young people who are not engaging in sexual intercourse will continue to abstain.
- Young people who are sexually active but who are either in a mutually faithful relationship with an uninfected partner or use condoms correctly and consistently will maintain those protective behaviors.
- Young people who are sexually active and are not in a mutually faithful relationship with an uninfected partner will refrain from sexual activity, choose nonpenetrative sex, or use condoms consistently and correctly.

Each PMI demonstration site is conducting research to identify youth's current behaviors in order to target youth with appropriate strategies promoting safer behaviors. The formative research will be used to define the behaviors that put the target audience at risk, to segment the target audience, and to set behavioral goals.

## **The research audience**

Each PMI site systematically reviewed available data, assessed existing community-based organizations' capabilities, and reviewed the overall political environment in order to begin to narrow the target audience from "all young adults 25 and younger" (the broadest PMI audience parameters outlined by CDC) to a more narrowly defined audience that could be reached

through the PMI intervention.

To begin, the PMI Community Council conducted a situation analysis, to better understand the dynamics of HIV in Sacramento. Because accurate HIV seroprevalence data for adolescents are not available, the situation analysis looked at proxy indicators of HIV risk — teen births and available data on sexually transmitted diseases (STDs). Data were examined by zip codes, to give insight into the geographic as well as demographic distribution of pregnancy and disease. Analysis of the available data found that pregnancy and STDs were epidemic for 13-19 year olds, with a majority of cases falling into 15 zip codes of Sacramento and Yolo counties. The data indicated that this group was most at risk for teen births and other STDs, and thus were practicing behaviors that increased the risk for HIV transmission.

Looking specifically at HIV and AIDS statistics, five reported cases of AIDS are among youth ages 13 to 19. In addition, a reported 365 young adults, ages 20 to 29, have AIDS. Together, these represent about 20 percent of all AIDS cases for Sacramento county through November 1995. Taking into consideration the latency period between HIV infection and the development of AIDS, it can be estimated that many of these young adults may have been infected with HIV during their adolescence.

Considering the epidemiological data and the political environment, an initial target audience cut was made to include 14-18 year old sexually active youth, living in 15 zip codes in Sacramento and Yolo counties. The formative research focused on these 14-18 year old youth.

### **Purpose of the formative research**

The qualitative research discussed in this report was conducted in order to supply the PMI Community Council with information about the target audience to design an HIV-prevention intervention. The research design sought to characterize the target audience in terms of their cultural *milieu*, their current knowledge of HIV/AIDS, their sexual practices and safer sex behaviors, their perception of risk for acquiring infection and their ability to control the risk, common and subgroup characteristics that will be important for the design of promotional strategies, and their sources of information on HIV/AIDS.

The request for proposals stated the purpose of the research was to assess the following among the at-risk 14-18 year olds in the target audience:

- knowledge, attitudes, values, beliefs, skills and practices concerning emerging sexuality and sexual practices and concerning safer sex behaviors (including condom use);
- sense of future and control of destiny;
- other areas related to preventing the sexual transmission of HIV, as appropriate.

# *M*ethodology

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Following a request for proposals (RFP) and a bidding process, the HIV Prevention Studies Group at the University of California at Davis (UC-Davis) was contracted to conduct focus groups and individual interviews. The UC-Davis team was selected by a team comprised of technical staff from the Academy for Educational Development and the formative research subcommittee of the PMI Steering Committee.

The University of California Davis Human Subjects Review Committee approved the project in April 1995. Under the direction of Dr. Neil Flynn, MD MPH, the UC-Davis research team conducted 24 focus groups and 40 individual interviews during the summer of 1995.

The target group for the formative research was teens ages 14 to 18 years, residing in the specified 15 zip codes in Sacramento county and their parents. Twenty-one young adult focus groups, consisting of 166 participants, were conducted. One group of males admitting same-sex activity, two groups recruited through church youth groups, and one group of homeless young people were included in the 21 young adult groups. Three parent focus groups, consisting of 22 parents, were also conducted. Thirty individual interviews were conducted with adolescents and 10 with parents.

## **Development of instruments**

The screening questionnaires, focus group guides, and individual interview guides were developed by Dr. Olga Grinstead of the Center for AIDS Prevention Studies at the University of California-San Francisco. The instruments were adapted to the Sacramento site by the UC-Davis research team. After several revisions the final versions contained in the appendix were agreed upon by the research team, the Academy for Educational Development, and the formative research subcommittee.

## **Recruitment of focus group participants**

Adolescent participants in the research were to be 14 to 18 years of age, preferably sexually active, from low-income families, and living in the identified high-risk neighborhoods in the Sacramento area. While participants were not required to be recruited to represent ethnicity, the study team ensured the participation of different ethnic groups as are represented in the target zip codes. Finally, researchers were asked to take into account risk behaviors among teens, and recruit participants who could present points of view on same-sex behaviors (gay and bisexual men), alcohol use, and drug use. However, because of the difficulty in accurately assessing teens' sexual experience in a screening questionnaire, and to strengthen analysis of determinants of behavior, youth were not required to be sexually active to participate in the

focus groups.

A number of recruitment strategies were identified and tried with varying degrees of success. Fliers were distributed by community agencies, in a few high schools, at the Thursday Night Market (a weekly summer street fair in downtown Sacramento that attracts large numbers of teens). The Thursday Night Market recruiting was very successful. Few participants were recruited from high schools because active recruiting did not begin until a week before the end of the school year. Community service agencies in the designated zip codes were also encouraged to send referrals, and focus group participants were asked to refer other teens (snowball sampling method). These two methods were also quite successful. One focus group was formed of homeless youth who live on the banks of the two rivers that run through the city of Sacramento.

### Identification of targeted zip codes

Recruitment efforts focused on finding participants residing in the 15 specific zip code areas. In the end, two-thirds of adolescent participants lived in the targeted zip code areas; most of the rest lived in immediately adjacent zip codes. The distribution of participant zip codes is outlined below.

**Table 1. Neighborhoods of focus group participants**

<i>Area</i>	<i>Zip code</i>	<i>Number of participants (total=166)</i>
West Sacramento	95605, 95691, 95616*	36
South Sacramento	95820, 95822, 95824, 95826, 95818*	32
Meadowview	95823, 95828	19
North Highlands	95660, 95842, 95621*	15
Downtown	95814, 95816, 95817*, 95819*	15
Del Paso Heights	95838, 95815, 95833*	7
Rancho Cordova	95670, 95827*	6
Other areas		26
Homeless		7
Unknown		3

\* indicates zip code other than target zip code

## Composition of focus groups

UC-Davis attempted to constitute focus groups that were relatively homogeneous within groups with respect to age (14-16 and 16-18 years of age), gender (all-male or all-female groups), sexual and alcohol/drug experience (16 year olds assigned to younger or older age groups depending on their sexual experience) in order to make participants as comfortable in the group as possible. Resources were not available to expand the research design to include separate ethnic segments. Therefore, ethnicity was not used as a criterion for assignment to a specific focus group in order to include all ethnicities in the research. And because Sacramento PMI hoped to reach all ethnicities, rather than limit the intervention to one or two, the additional advantage of mixed groups was to evaluate whether there were similarities among adolescents of different ethnicities in Sacramento on which to base one community-level intervention.

There was a good mix in the sample of age, gender, ethnicity, and experience with sex and alcohol/drugs. Fifty-five percent of participants were female. Fifty-seven percent were people of color or a member of an ethnic minority. The majority of youth were sexually active, but participation was not limited to sexually active youth. Experience has shown it is extremely difficult to accurately screen for sexual activity. Many respondents do not provide accurate information, and later “confess” to a different sexual history. Also, for research purposes, researchers were interested in contrasting the responses of those engaging in penetrative sex to those not for a variety of variables, to better understand the determinants of risk behavior. Lastly, the study hoped to better understand the spectrum of sexual risk and decision-making, and wanted to include those not having penetrative sex in the data.

**Table 2. Description of focus groups**

<i>Gender</i>	<i>Description</i>	<i>Ages</i>	<i>Number of groups (total = 24)</i>
Female	Heterosexual	14 - 16	7
Female	Hetero- and bisexual	14 - 16	1
Female	Heterosexual	16 - 18	2
Female	Hetero- and bisexual	16 - 18	1
Male	Heterosexual	14 - 18	1
Male	Heterosexual	16 - 18	3
Male	Hetero- and bisexual	14 - 18	1
Male	Homo- and bisexual	16 - 18	1
Male	Hetero-, homo-, and bisexual	16 - 18	1
Female	Churchgoers	14 - 16	1
Male	Churchgoers	16 - 18	1
Male and female	Homeless, heterosexual	14 - 18	1
Male and female	Parents		3

## **Moderators**

Focus group moderators were selected through referrals by the formative research team at UC Davis, members of the PMI Steering Committee, and community service organizations. Major criteria for selection were experience with focus group methodology and group interview skills, anticipated appeal to participants, and knowledge of HIV and the target population. Three Caucasian women and one Caucasian male conducted the focus group interviews. Because the groups were of mixed ethnicity, it was impossible to match ethnicity of all focus group participants. Almost half of focus group participants were Caucasian, so a match was achieved about half of the time. Gender match was considered, and matched in many groups; the female moderators conducted a number of male groups as the male moderator was not available.

## **Mechanics of the focus groups**

The focus groups were conducted according to the protocols approved by the UC-Davis/Human Subjects Review Committee (Institutional Review Board). Major features of the protocol included: informed consent from both the young person and from her/his parent/guardian unless s(he) met the definition of an emancipated minor under California law or was 18 years of age; a signed pledge of confidentiality; a thorough and complete description of the content of the focus group discussions; and a referral for further information or assistance.

Focus groups were conducted in community service agency facilities located in the area from which participants were recruited. Each focus group was conducted by a moderator, and notes were taken by an observer, a member of the research staff. Most focus groups were audiotaped for transcription and analysis. Participants were given food and \$25 as incentives for participation.

Every moderator and observer of the groups was required to complete a statement of their general impressions of the group, and particularly intriguing ideas brought out in the group, and to identify individuals in the group who would provide informative individual interviews.

## **Individual teen interviews**

Selection criteria for subsequent individual interviews following the focus groups included: participants with interesting ideas, representatives of a viewpoint that the research team wanted to explore in more depth, or participants who were particularly articulate and expressive. Individual interviews were conducted by the focus group moderators or by UC-Davis research staff, guided by the individual interview questions. The interviews were purposefully free-ranging, and lasted about an hour. Interviewees were given \$25 for their assistance. Most interviews were audiotaped and later transcribed for analysis.

### **Table 3. Demographics of adolescent individual interviewees**

<i>Ethnicity</i>	<i>Number of females (total = 16)</i>	<i>Number of males (total = 14)</i>
African American	3	2
Latina/o	1	3
Caucasian	7	6
Mixed ethnicity	5	3

\*Interviewees who reported mixed ethnicity said they were Latino/Caucasian (1), African American/Caucasian (1), African American/Native American (1), Latina/Native American (1), and Native American/Caucasian (4).

**Table 4. Adolescent individual interviewees by age**

<i>Age (years)</i>	<i>Number of females (total = 16)</i>	<i>Number of males (total = 14)</i>
14	3	1
15	4	1
16	4	3
17	3	4
18	2	5

### **Demographics of parent focus groups**

Three focus groups were conducted with parents of teens. Twenty-two parents participated in these groups, 15 of whom were mothers. The parents represented diverse socioeconomic levels and had very different viewpoints on the various topics discussed. However, they worked in the groups quite well together, “agreeing to disagree.” One mother was Latina, five were African American, and eight were Caucasian. Four of the fathers were Caucasian and three were African American. The parents ranged in age from 34 to 59 and, collectively, were the parents of 36 adolescents. Some of the parents represented teenagers who had sexual experiences and used drugs, and some did not.

### **Demographics of parent individual interviews**

Ten individual interviews were conducted with parents of teens. Eight mothers and two fathers were interviewed. One of African American is the father of three adolescents. The other is Caucasian and is the father of two teens. The ethnicity of the mothers were: four African American, three Caucasian, one Latina. Two mothers did not participate in the focus groups; one of them was recruited because she is the mother of six children, the youngest is 16. She has been raising teenagers continually since 1979.

## **Process of analysis**

Following the transcription of the audiotapes of the focus groups and the individual interviews, the UC-Davis team reviewed each transcript and added comments from the moderator and observer notes. The UC-Davis team, together with PMI partners, conducted an extensive content analysis of findings. A draft report summarizing the focus groups and the individual interviews was written, focusing on:

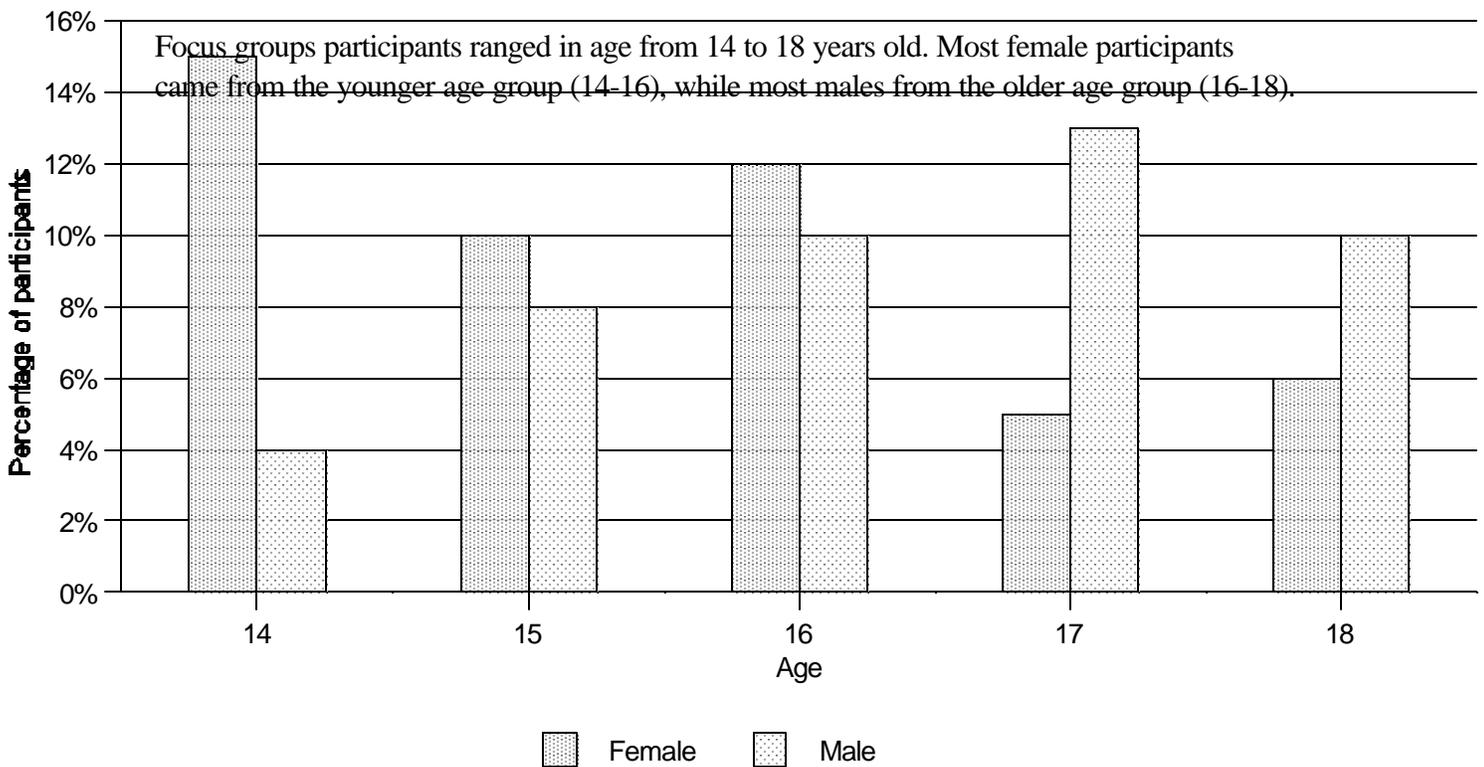
- Summarization of responses, indicating strength of consensus with a particular viewpoint, within and between focus groups and individuals, and description of significant divergent opinions.
- Identification of barriers to risk-reduction suggested by participants' responses.
- Identification of potential facilitators of risk reduction.
- Exploration of the determinants of risk and protective behaviors.

# **A** *nalysis of the respondent quantitative checklist*

A short demographic and behavioral checklist was administered anonymously to each focus group participant prior to beginning the focus group. A total of 166 questionnaires were completed. This section presents the quantitative analysis of the questionnaires.

## **Demographics and home life**

### *Age*

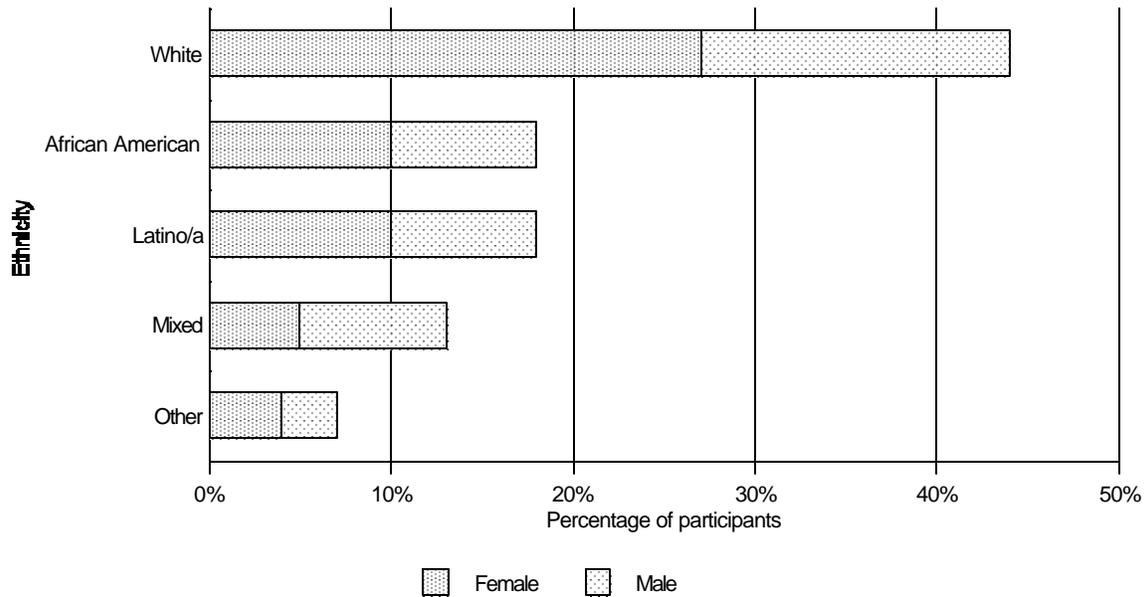


**Figure 1. Age of focus group participants**

## *Ethnicity*

Focus group participants were from all the ethnic groups found in the target area. Most participants were Caucasian, which is also the largest ethnic group in the area.

**Figure 2. Ethnicity of focus group participants**



## *Sexual orientation*

Most participants reported being heterosexual. Special recruiting assured gay and bisexual representation in the research activity.

**Table 5. Sexual orientation of focus group participants**

<i>Sexual orientation</i>	<i>Percentage of participants</i>
Heterosexual	89%
Homosexual	3%
Bisexual	4%
Other	4%

### *Social identification*

Participants were asked to identify their social group(s) from a closed list of group characteristics. The most mentioned social group for self-identifications were “stoners”, followed closely by gangs, jocks/cheerleaders, and preppies.

**Table 6. Social group of focus group participants**

<i>Self-identified social group*</i>	<i>Percentage of participants</i>
Stoners	19%
Gangs	16%
Jocks/cheerleaders	14%
Preppies	13%
Academics	6%
Radical/political	5%
Other groups	11%
Many groups	9%
None	17%

\* Multiple responses were given by some participants.

### *Home life*

Two fifths of participants reported living with both parents. About a third lived in single-parent households, the majority of these headed by a single mother. Young adults recruited through churches were more likely to live with both parents, the “mainstream” young adults were more likely to live in single parent households.

**Table 7. Focus group participants' living arrangements**

<i>Living arrangements</i>	<i>Percentage of participants</i>
Parents	40%
Single mother	31%
Parent and step-parent	5%
Other family	6%
Friends	5%
Single father	4%
Homeless	4%
Other	5%

Most participants reported that the parenting adult in the home makes the rules.

**Table 8. Household rulemakers**

<i>Rulemaker in the household</i>	<i>Percentage of participants</i>
Parent or other adult	82%
Self	8%
Together with parents	6%
No rules	2%
Friends	2%

About 60 percent of the participants reported that the rulemakers have a lot of influence over the youth's behavior

**Table 9. Rulemakers' influence**

<i>Rulemakers' influence</i>	<i>Percentage of participants</i>
Total	11%
A lot	50%
Some	32%
None	4%
Other or refused	3%

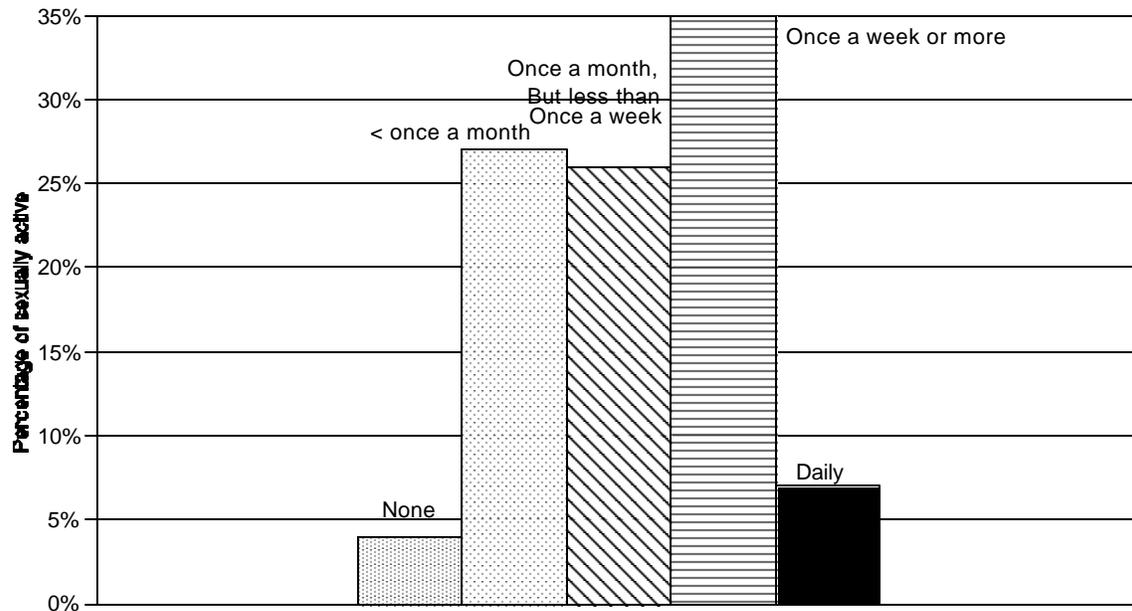
## Sexual behaviors

Eighty-one percent of the focus group participants reported they had willingly engaged in some kind of sexual activity<sup>1</sup> (including heavy kissing and petting), and 84 percent of these (114 individuals or 67 percent of the total) reported ever having had oral, vaginal or anal intercourse. About a third reported no history of penetrative sex. Homeless youth were more likely to have had intercourse than the research population overall; young adults recruited through church were less likely to have had intercourse.

Of the 135 sexually active participants, 68 percent report sexual activity once a month or more. Twenty-two percent of the sexually active participants had sex less than once a month, and 3 percent had had no sex in the last six months. In retrospect it is clear that respondents interpreted this question in different ways. Some reported on frequency of intercourse and others on frequency of sexual activity, broadly defined.

Respondents recruited through churches were more likely to have sex less frequently than other respondents. Gay males were also reporting sex less frequently than their heterosexual counterparts.

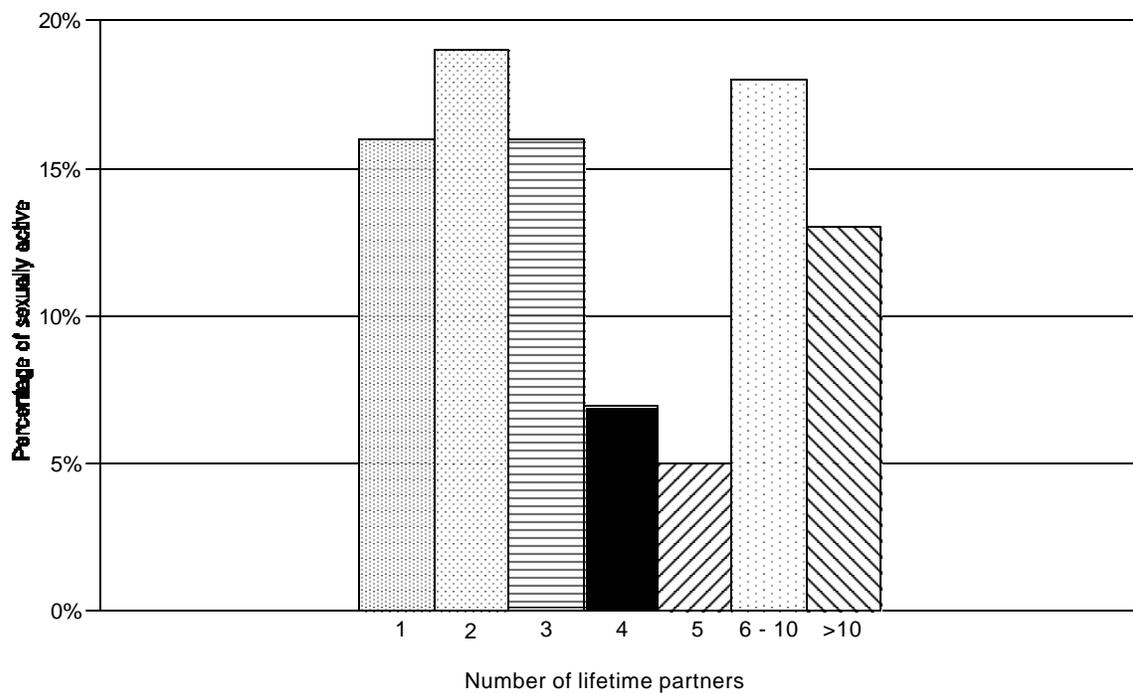
**Figure 3. Sexually active focus group participants' frequency of sex in last six months**



<sup>1</sup> "Sexually active" is defined as heavy kissing, petting and other sexual activity, and does not necessarily include intercourse.

Almost three fourths of those reporting sexual activity (or 55 percent of the total) reported having had more than one partner in their lifetime. Twenty-six percent of the sexually active reported six or more lifetime partners. Heterosexual respondents were more likely to have had several lifetime partners more than gay respondents. Males reported more lifetime partners than females. Respondents from single parent homes and homeless youth reported more partners than respondents from two-parent homes. Little age difference was seen in number of partners, except at the extremes, where younger respondents had fewer partners and older respondents more likely to have had more than 10 partners. Again, respondents seemed to interpret this question differently, some answering the number of partners with whom they had had intercourse and others the number with whom they had had any kind of sex.

**Figure 4. Sexually active focus group participants' number of lifetime partners**

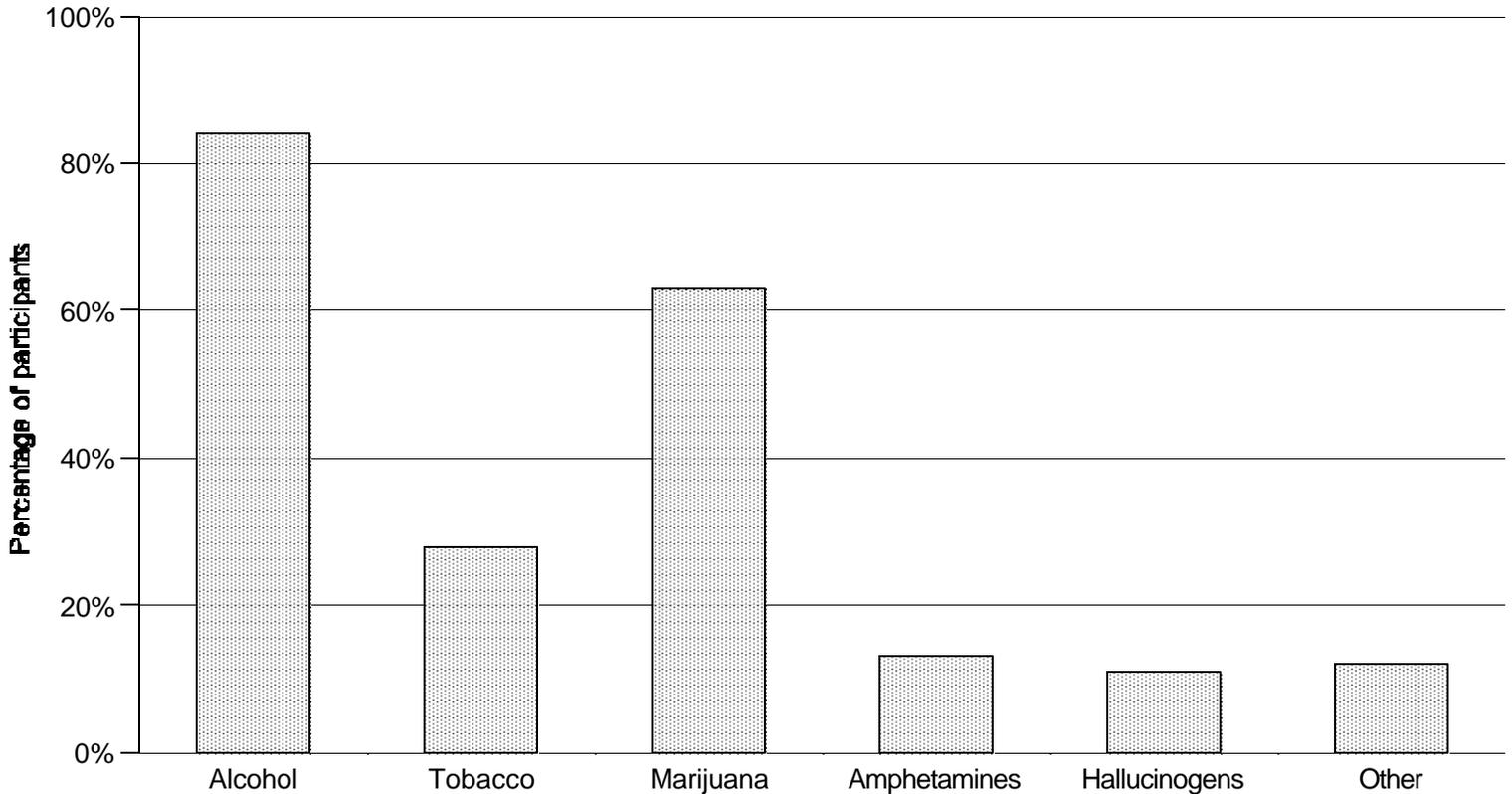


Four percent of participants reported ever having traded sex for money or drugs.

## Substance use

Most focus group participants have tried alcohol and many have used marijuana. There was a relatively low level of experimentation with cigarettes among the sample. Relatively little “other drug use” was reported by participants.

**Figure 5. Focus group participants’ ever use of drugs**



Note: Tobacco use was not asked of three focus groups, thus results underestimate use.

Eighty-four percent reported ever using alcohol; 90 percent of these (or 76 percent of the total) had consumed alcohol in the six months prior to the focus group. Participants who reported drinking in the last six months consumed beer (34 percent), liquor (25 percent), wine (17 percent), or a combination of these (14 percent).

Approximately two-thirds reported ever using marijuana, and 94 percent of these (or 63 percent of the total) had smoked marijuana in the prior six months.

A fourth of participants reported illicit drug use other than marijuana, and 85 percent of these had used drugs in the six months prior to interview. The drugs used were amphetamines (54 percent of illicit drug users), hallucinogens (46 percent of users), inhalants (15 percent of users), and cocaine (10 percent of users).

**Table 10. Frequency of substance use**

<i>Frequency of substance use in last six months</i>	<i>Alcohol (percentage of 139 participants who have ever used)</i>	<i>Marijuana (percentage of 104 participants who have ever used)</i>	<i>Illicit drugs other than marijuana (percentage of 41 participants who have ever used)</i>
None in last six months	10%	7%	15%
Once	5%	9%	17%
Less than once a month	36%	28%	32%
Once a month	16%	2%	10%
Less than once a week	8%	15%	5%
Once a week	12%	9%	7%
More than once a week	10%	14%	5%
Daily	4%	16%	5%

### **Legal history**

More than a fourth of participants reported prior arrest; 99 percent of the arrested youth reported alcohol use, 87 percent reported illicit drug use, and 39 percent reported illicit drug use other than marijuana. Seventy percent of the homeless youth had arrest records.

# **S**ummary of teen focus group findings

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## **Teen self-esteem, social relationships, and activities**

Hanging out at friends houses (“kickin’ it, going to parties), going to the malls, coffee shops or parks, drinking or doing drugs, playing music and participating in sports are some of the most frequently named activities mentioned across all focus groups. Most of the teens hang out with friends/acquaintances, both male and female, who are their own age and up to eight years older.

*“I hang out with older people because younger people or people my age, they seem to want to compete with you. I try to hang out with people who can help me out, who can teach me something.” (17 year old male)*

*“Hang with my friends who are mostly guys about my age. We get loaded and kick it.”(18 year old male)*

*“Pretty much hang out with friends and drink and get high.” (15 year old female)*

*“We like to hang out at the park, and go over to one of our little coffee shops, talk and listen to music, drive around people’s houses, and go to parties.” (14 year old female)*

Especially for females ages 14-16, there is a tendency to hang out with older males and females. Some females preferred male companions (friends) for hanging out because they were seen as more “trustworthy.”

*“You have friends from about 13 to 18. School friends are mostly 16.” (15 year old female).*

*“I hardly have freshman friends, most of my friends are age 16-22, from sophomores to graduated and in college.” (14 year old female)*

*“Our friends are totally different in age. Most of the guys are a lot older like 20. The oldest friend is 23 and 24.” (16 year old female)*

*“ I don’t like to meet new friends because I don’t trust everybody. I trust mostly guys because the girls are gossiping and stuff.” (15 year old Latino female)*

### ***What's cool***

'Cool' and 'uncool' are powerful determinants of teen opinion. Being cool means acting in a way that attracts favorable attention of peers and entertains them: doing cool things, having an "attitude" or style that others in peer group find interesting, entertaining, or funny. Cool can include fashion, music of several varieties, using cool language, and body language. It may include going along with the crowd or it may be "doing your own thing" (individuality), depending on the circumstances. You can be cool within your own group, but being seen as uncool by members of other groups is also cool within your group. There is a duality to adolescents' thinking with respect to being cool by going along with the group, versus by being individualistic. They say they like being different and individualistic but the "individualism" conforms to the norms within the group. This attitude was present in many groups, and it crossed ethnic lines. Young gay or bisexual males reported feeling less concerned with peer norms (from the "general population") than heterosexual respondents. Feeling already "outside" the crowd, they said they were comfortable going against the norms if they felt different than the group. This may be an artifact of recruitment, as all participants were recruited through the Lambda (gay service and support) Center, and therefore may be more connected to another peer group than other young males who are just "coming out" or experimenting with same sex behavior.

*"In my group we don't really look for fads and stuff, we just wear whatever we want, really. We don't copy anyone, we try to be originals. If other people are dyeing their hair green, then we want to dye it pink. It's just that we want to be original." (15 year old Caucasian female)*

Words for "cool": sweet, tight (several female groups), tight ass, hella' tight, cous' (like cousin, to refer to friend who is being cool, female group), bong, bongest, rad, sick, stoked, killer, fucked-up, OK, dude, ass, groovy, down, bow, pendicular, that's a trip, nifty, bitch, raw, federal, the bomb, C, mon (variation on man), bomb rips, hip, fly.

Words for uncool: don't go there, bootsie, trash, use swear words, preppy, stupid, foolio, jankey, dorky, tawdry, she looks like she's all bad, trifling, disgusting, suck, loser, dork, nerd, freak, lame, retarded, studio, domino, whacked, a tweaker, broken, garbage, full rank, dusty, faulty, hurt, nasty, bitch, raw, hoe, scandless, bag whore, tramp, eat toes, dumb, stupid, jerk, foul, mark, trick, dry snitch, hood rack, queer, fuck-face, a mark, faggot, dry snitch, hood rack.

### ***Dating behavior***

Even though females often stated that having a boyfriend was not of great importance, they were often the ones who were sexually active. For example, in one female focus group, two 15 year olds and one 16 year old claimed it was not important to have a boyfriend, but the same females were sexually involved with one or more males.

*“Sometimes you get bored and desperate.” (14 year old female)*

*“It ain’t important, but if you do it’s cool.” (17 year old African American female)*

*“It’s not like you got to have one but you feel kind of empty not having nobody...it’s not the first thing in the world but it’s like: where is a boyfriend, where is a boyfriend?” (16 year old white female)*

*“People go through boyfriends like they go through styles.” (15 year old white female)*

*“Sex is cheap, it can last for 15 or 20 minutes and then it is over, and OK, I’ll go home now, it’s nothing, it doesn’t mean anything. (14 year old Native American female)*

Heterosexual males explicitly stated the importance of “getting” a female and appeared to gain peer status by having female sexual partners. This also held true for the one gay/bisexual male focus group.

*“I think with men we are just a lot more sexual. It is a lot easier to go to bed with men than it is with women.” (16 year old gay white male)*

Females, in general, had a concept of a “relationship” that went beyond sex. Some were also quite comfortable talking about the pleasures and/or benefits of ‘casual sex’ without an accompanying relationship.

Males focused on the sexual benefits of relationships and showed little interest in developing relationships for motives other than sex. Males who did make reference to “deep” relationships most often thought that was a future aspiration, not a current goal.

Often grudgingly, males perceived that women were ‘high maintenance’ in that the boyfriend was expected to do things for a girlfriend in order to have sex. Having sex without having the “boyfriend” status meant less obligation and fewer wining and dining activities.

*“You are always searching for female companionship. The eternal quest.” (17 year old male)*

*“It’s more a social requirement.” (18 year old male)*

*“It’s a weekend hobby” (17 year old white male)*

*“Most people just be fucking they don’t be going with each other. Try to hook*

*them up and get them a freak. . . if they pass away, then go to somebody else.”*  
(15 year old African American male)

*“We accept them as long as they have a girlfriend.”* (17 year old Latino male)

Females more than males talked about “going” with a guy for certain lengths of time. This “going” period ranged from a few days to two years at most. Behavioral norms varied when “in” and “out” of a relationship and the length of relationships varied widely.

*“I’ve had the same boyfriend for almost 10 months. I’m really happy with being with him and I am glad that I found him. I think we might stay together forever.*  
(15 year old white female)

*“For my first time that my boyfriend and I were together for like not even two months. . . but I just wanted to try it, and my friend was doing it so I did it. And three weeks later we broke up and it was just horrible.”* (18 year old white female)

Some females mentioned that they regret becoming more intimate with boys who were just friends.

*“Sex ruins the friendship...it blows it up a friendship a lot of the time. . . if you break up you are lucky to stay friends. Is it worth totally trading the friendship for the other half of the commitment?”* (16 year old white female)

**Table 11. Similarities and differences between heterosexual female and heterosexual male focus group participants**

<i>Concept</i>	<i>Females</i>	<i>Males</i>
Hanging out	Activity-centered: skating, biking, going to the mall, sports, parties, movies, sitting around and talking, drinking, smoking weed, doing other drugs	Activity-centered: skating, biking, going to the mall, sports, parties, movies, flirting, drinking, smoking weed, doing other drugs.
Importance of sex in dating	Have to have sex to have love and trust; will keep having sex if it is good. Sex is an important activity.	Most automatically have sex with or without commitment, will find someone new if sex is not good or if another person comes along. Sex is important.
Reasons to have sex	Pressure from boys, to get attention, to feel loved and needed, to be more popular.	Impress friends, to prove you are not gay, feels good, good activity and cheap.
Abstaining or delay	Will wait for some time in new relationship, but not too long.	Some decide not to have sex and respect girls who also choose not to have sex.
Will stop having sex if:	Sometimes if he found someone new or went back to old girlfriend; recently had baby and does not want more; scared of boyfriend.	Do not like person anymore; out of revenge; have too many partners, knew someone who died of AIDS
Safer sex	Condom (latex), Depo, Norplant, birth control, abstinence, trust in boyfriend.	Condoms and abstinence, trust in girlfriend; more likely to use if condoms are free, prefer ribbed and thin condoms.
Getting the message	Fear of consequences (pregnancy at young age, HIV or STDs), illness and death of someone they know.	Fear of pregnancy and HIV, scary and believable, with kids talking to other kids who have been affected by AIDS or pregnancy.

## Sexual behavior

Out of the 166 focus group participants, 114 (67%) report on the prescreening checklist that they have engaged in sexual intercourse. In focus group discussions, most of the participants admitted they had not planned to have sex their first time nor planned for subsequent times. It just happens. One male says *“it was like the game mouse trap for me and I had the ball.”* (17 year old white male)

For a few females, they asserted that they don't necessarily start out thinking that they are going to have sex, but feelings take over, and one thing leads to another.

*“I think that some people maybe start out intending to kiss and everything, but it just gets carried away. (18 year old white female)*

Several females felt that it may not be worthwhile to yield to the pressure to have sex, because boys are unfaithful and may just dump you after they get what they want. Others felt like they needed to “trust” their boyfriend and might lose the boyfriend if they didn't have sex.

*“You could lose everything you have in the relationship...the guy could leave.”* (15 year old white female)

A few of the males said that the female has more “power” in deciding whether to have sex. But a simple statement of disinterest or “not now” was not always effective for a female to say to a male when she did not want to have sex. According to both males and females, men did not take “no” to mean “no.” Often, both females and males revealed that the female had to resort to “hitting, kicking, pushing, and yelling” to get the male to stop.

Gay and bisexual males felt that, in general, males are more sexual than females, suggesting that both gay and heterosexual men aren't able to choose abstinence.

Common terms for having sexual intercourse used by both male and female focus group participants were: bud, boff, doing it, bump and grind, fucking, screw, hide the salami, monkey dance, freakin' it, bump and burn, yanking, Mikey climbed a tree, Mikey went in the garbage, slamming it, slamming 'em, killing 'em, stick, being trashy, getting busy, getting it on, got a hump on, heating it up, hittin' 'em, fucking it, get some ass, making love, sixty-nine, hit her insides, bootie job, beatin' that shit up, poundin' it, boning, a fling, blow job, suckie yuckie, hubba hubba, tooky wooky, pootah, getting laid, getting pussy, give me kabba, getting laid, bone, bumping, hippos, in the sticks, booty call, midnight call for sex.

Terms for sexual intercourse were considerably more violent from male participants than female participants, they included: fuckin' hippos, slabbing guts, in the sticks, hittin' it, pumping heads, butt fuck, getting pussy, killin' 'em, giving your nut away, ripping up gut, turn the shit up. However, one participant claims that if he were “in love” he would use the words “making

love.”

*“If it were somebody you just met on the street, I would call it fucking, but if it’s somebody you love and everything then it’s called making love.” (17 or 18 year old male)*

Females on the other hand were more likely to use the terms: intercourse, dating, making love, having sex, screwing, sleeping around, fucking, nailed, Humma Humma, Freak, Bump and grind, Bonin’, get a hump on, ho-ing, get some ass.

There was some stigma against females who are very sexually active; little stigma was expressed against sexually active males.

### ***Why teens have sex***

Across the groups, responses were similar for why teens have sex. They reported to have sex because of:

- pressure from boyfriend or girlfriend that eventually wears you down, and from friends in general
- physical attraction and desire
- demonstration of love
- emotional rewards: love, attention, closeness, and intimacy
- curiosity.

For sexual relations to continue, both males and females say it depends on whether the sex is good, not boring, and if the interest continues. The males say they have sex because it feels good, relaxes you, and makes you feel good about yourself.

### ***Where teens have sex***

There were a variety of places mentioned across groups where teens are having sex. These include their bedroom, their partner’s bedroom, a friend’s bedroom, in homes, in cars, in the park, at the river, at school in the bathroom, and in the bathrooms of local fast-food restaurants including Taco Bell, McDonald’s and Burger King.

### **AIDS/HIV knowledge**

Overall, teens demonstrated fairly good knowledge about HIV disease transmission and protection. Male participants’ knowledge was generally less than females, with males mentioning a number of incorrect modes of transmission. Most confusion was around other types of “bodily fluids” — pus, urine, and so forth. A few males also expressed skepticism that all the information they had received was true.

*“Like, I think you could catch it, like, a lot more ways than they are telling you. I think you can get it from touching somebody.” (Male, 14-18 year old group)*

Some males were flippant when discussing AIDS, one referring to AIDS as “Hemorrhoidal Inflation Value.” Gay males were generally more informed than heterosexual males.

There was poor knowledge of the HIV risk hierarchy. The risk of oral sex was often discussed among participants, with little conclusion.

### **Saliency of HIV**

AIDS/HIV was very close to focus group participants. Of the 166 focus group participants, 54 mentioned that they knew people personally who have or had AIDS. Several participants mentioned that the people they knew were more than casual acquaintances, such as uncles, boyfriends, friends, and cousins.

*“I really didn’t understand the magnitude of it until my friend got AIDS. He died of it.” (15 year old white Caucasian male)*

*“I have a friend, I have an auntie, she died of AIDS. She used to use drugs, heroin. And one of my cousin’s friends she has AIDS and is still having babies and still having unprotected sex.” (15 year old African-American female)*

*“You want to understand it because when you see somebody die that you know. I mean there is anger but at the same time you want to reach out to other people and you want to let them know what is going to happen.” (14 year old white female)*

*“I had an uncle that was my first exposure to it. And watching him go through all that (like when his T-cell count went down) opened up my eyes that this can happen to anybody.” (17 year old Latina female)*

*“My friend had AIDS and a family member had it too. He got it from shaving, he used the same razor blade that the guy had bloody and 3 years later he found out he had AIDS and now he is hella sick.” (16 year old Latino male)*

Some participants felt they could have been exposed to HIV.

*“You know that you are not invisible, you are here on earth. You have a chance to get it from anyone else as much as they have a chance from getting it from you.” (15 year old African American female)*

Many participants mentioned that through knowing someone with AIDS they were more aware of the consequences of getting AIDS and therefore practiced safer sex. For many others, the linkage between knowing someone with AIDS and adopting protective behaviors was less clear, as was the unclear relationship between their own perceived risk and safer sex behaviors.

*“I think some teenagers think they are invincible...Personally I think I am going to die and I may die of AIDS and that would be very scary. Nobody wants to die so try to protect yourself and try to avoid getting it. That is the best you can do.”*  
(17 year old Latino male)

## **Condom use**

Teens do appear to have a high level of awareness about condoms and safe sex. Many of the sexually active teens have used condoms at least one time. Overall, focus group participants were knowledgeable about condom availability and their value in preventing disease and pregnancy. Some said they used condoms consistently in all situations. These males and females were adamant about the importance of always using condoms.

*“It’s my way or the highway.”* (17 or 18 year old white male)

*“Like these people say using a condom is interrupting the passion and that you have to stop. But if you really care for that person it shouldn’t matter. I think it really shows that you really care for that person you have sex with if you do ask for a condom.”* (17 year old Latino male)

Others reported sporadic condom use; for these teens, condoms were used more in certain situations than in others.

### ***Condom use in the context of “serious” and “casual” relationships***

Focus group discussions indicated that condom use decreased as the duration of the relationship increased.

*“Not all the time. . . but most people I know it is, like, “try” as much as possible.”* (15 year old white female)

Reasons for not using condoms included:

- trust/love of the partner

*“I know that, most people, that their first time or they did it without a condom once, they don’t want to use a condom and they end up not using one. They trust their partner.”* (18 year old African American male)

- inconvenience of putting on the condom, interruption of foreplay

*“I hate when you have to get up and throw the wrapper away. You can’t just leave it laying in your bed to add to your collection.”* (16 year old white female)

- drugs or alcohol

*“Sometimes you drunk and you sometimes forget about it or it’s too confusing.”  
(18 year old Latino)*

*“When you’re frying, that shit’s hard.” (14 year old white/Latino male)*

- access (lack of access to purchase or more often, not available at moment)

*“It’s hard to get them there, because where I live they won’t sell them.” (15 year old white female)*

*“Some guys forget them on purpose so they won’t have to use them.” (15 year old white female)*

- embarrassed and scared to buy or use
- expensive

Some participants spoke knowledgeably about proper condom use. Respondents were not asked to demonstrate or describe proper condom use, so there is no way to estimate correct knowledge of condom use other than through interpreting the number of “bad things” mentioned below that are outcomes of improper use.

Most participants knew that the latex condom was the safer and more effective condom to use. Some male participants mentioned using thinner or ribbed condoms to preserve “the feel.”

### ***Barriers and negative attributes of condoms***

When specifically asked about negative things associated with consistent condom use, both male and female participants showed skepticism, including a range of answers around condoms as ineffective, breaking/leaking, hurting, decreased sensation or improper use.

*“Some guys can’t stay up and don’t feel comfortable, and therefore the sex sucks.”  
(16 year old white female)*

*“When you have sex with a condom, it rubs...you can get a yeast infection or a bladder infection...and a man can get a rash from a condom.” (17 year old African American female)*

From a few participants, condom use was associated with distrust or lack of respect.

*“One of the reasons I don’t like using condoms with my boyfriend is because it makes*

*me feel cheap. It makes me feel like if we use a condom then he can go out and sleep with anyone else.” (18 year old white female)*

*“He thought I was messing around with somebody else. It cost me the relationship.” (15 year old white female)*

### ***Benefits and positive attributes of condom use***

Condoms were generally recognized as providing protection from pregnancy and STDs. Condom use in general is associated with pregnancy prevention more than reducing the risk of HIV/AIDS and other STDs. But participants talked about preferring the ease of pills or Norplant for birth control as opposed to condoms.

A few participants, of both genders, mentioned mutual respect when making a conscious effort to use condoms.

*“Respect for your partner and respect for yourself.” (14 year old white female)*

### ***Talking about condoms***

Talking about using a condom is not a common practice for teens. The general feeling is that discussion ruins the moment and makes things seem too planned. A number of respondents, particularly female, felt there was no “good” time to talk with partners about condom use. Talk before a relationship had become sexual implied promiscuity, and talk during sex was a turn-off. Introducing condoms into an already sexual relationship implied infidelity or lack of trust for both males and females.

*“Yeah, if you’re just kissing and you don’t know if you’re going to go that far. You’re not going to say: ‘Do you have a condom? Because that makes you, makes the guy think, oh boy, okay, I’ll plan on it. You don’t bring it up that soon.” (16 year old white female)*

However, there is a higher sense of control and self-esteem connected with those who discuss the issue with their partners.

*“Sometimes women aren’t very persuasive. I mean sometimes the guys just don’t want to wear the condom. . . They try hard to say, ‘you really need to wear this’ and it is just sort of like okay he doesn’t want to wear it.” (17 year old Latina female)*  
another participant adds *“He goes, I will pull out.”(16 year old white female)*

### **Attributes of condom users and non-users**

### ***Reaction to male who always uses condoms***

Almost all male and female participants spoke positively of someone who insists on using a condom all the time. The most common reactions to a male who always uses a condom were:

- “smart” and
- “responsible”

Other comments included “educated,” “cool,” “great guy,” “level-headed or thinking,” “safe,” “a regular person,” “caring,” “knows what he is talking about,” “doesn’t matter,” “a friend,” “I’d love him,” “respectful.” But a few female participants had negative association with consistent condom use, suggesting that “maybe guy is scared or has something.”

### ***Reactions to a female who insists on using a condom***

As for males who always use condoms, both genders positively described a female who always insists on condom use. The most commonly mentioned word to describe a girl who always uses a condom was “smart.” Other descriptors included: “has sense” (and “good head”), “protecting self” (or “safe”), “thinks,” “respect for self,” “responsible,” “good will power,” “strong,” “health conscious.”

Some males spoke of respect or trust for females insisting on condom use. But as with the question about males who always use a condom, a few participants inferred that a girl always insisting on condoms was not to be trusted.

### ***Reactions to a male who refuses to use a condom***

Many males used the terms “stupid or dumb” to describe another male who refuses to use a condom. Most other words used by both genders to describe a male who refused to use a condom were negative; most common were:

- “jerk”
- “disrespectful”
- “digging his grave”

Other words males used to describe other males were “dirty,” “slut,” “selfish,” and “scary.”

Some of the terms females used to describe males who do not use a condom were:

- “stupid” (includes imbecile, ignorant, and idiot)
- “jerk/asshole”

Other words females used included: “irresponsible” (also mentioned were careless/dangerous/insane), “no self respect,” “disrespectful.”

Three males used the term “all right” to describe a male who will not use a condom.

### ***Reactions to a female who never wants to use a condom***

Mostly negative terms were used to describe a girl who did not want to use a condom; the most common words were:

- “stupid” or “dumb”
- ‘ho/slut’
- “irresponsible” (includes not thinking)

Also mentioned were: “dirty,” “she wants to get pregnant,” “needs help or education,” “AIDS candidate,” “suicidal,” “sleeping around,” and “horny.” In addition to the above comments from both male and females, other male reactions showed fear and distrust.

- “She must have a reason; she is out to get you.”
- “I wouldn’t touch her.”
- “I’d be scared; can’t touch her.”

### **Condom access**

Most participants were aware of places to get condoms. Some mentioned access as a barrier to using condoms consistently, but not having one at the ‘right time’ seemed more of a problem than inability to get condoms.

*“I went to the store and I went looking for them and I couldn’t find them.” (16 year old African American female)*

Males more so than females appeared to be deterred in using a condom due to their expense. A few thought it was not worth having sex if they were forced to buy condoms, and others said if the female wants to use condoms, she will buy them herself, or at least she *should* buy them.

Some of the places mentioned to get condoms were:

- Clinics  
*“You all get condoms free at the AIDS Foundation.” (18 year old white female)*

- Stores

- Friends

*“I got a friend that if I give him some weed, he will give me a whole big box.” (18 year old white male)*

*“My friends pass them around.” (17 year old Latina)*

- Parents

*“They are very available. My mom has a drawer in her house that is where I go to use them.” (15 year old white female)*

### **Abstinence and sexual delay**

The issue of abstinence came up mostly from female focus group participants. The main reason females chose to delay initiation or abstain is out of fear of pregnancy, STDs or HIV. Another key reason females mentioned to abstain is due to life plans or goals. Several mentioned wanting to graduate from high school, go to college, work and get married the “right way.”

*“Abstinence: not the easiest way, but definitely the best.”*

Many participants said they knew someone who was abstaining from penetrative sex. Of those who spoke in focus groups about abstaining, they did not report this as a choice for disease prevention, but as a personal choice not to have intercourse at the present time. Although many of the teens knew individuals who were not sexually active, there was strong agreement that once sex had been initiated, abstinence was not an option: *“There is no going back.”* These responses were heard across gender, ethnicity, age, and sexual orientation. The exception to this belief was expressed by young women who were either currently pregnant or who already had children. Some teens are avoiding penile penetration, while engaging in other (presumably less risky) sexual activity. There were few self-reports of this behavior; although it was mentioned in a number of groups that teens were always talking about *others* choosing this option.

*“We just talked and we agreed that we were not going to do it. He’s not a virgin but I am and I want to maintain that. It depends on the person and how much respect you have for one another.” (16 year old white female)*

*“Take responsibility in whatever actions you do. You know you get on his bus and you know it is the wrong bus. You know you are going to be late going home. At 16 you are half grown at age 18 you are legally grown. You have got to take responsibility.” (15 year old African American female)*

Some girls talked about the negative consequences of abstinence, ranging from losing the boyfriend to being forced to have sex.

*“Or he could cheat on you and get it somewhere else.” (15 year old white female)*

*“Or he can say, well I want to have sex anyways and just take advantage of you*

*and hold you down or something.” (15 year old white female)*

*“This one guy he, like, liked me or something, and he couldn't believe that I have never done any of these things. He's like: 'you're lying, and I know you're lying.' and he's talking to his friend: 'she's just lying.' I go: 'you know, you don't have to believe me, it's not like I'm going to do anything with you anyway, so.' It used to bother me because they couldn't believe it, and they said that I was a liar; but I don't really let that bother me now, because it's my life.”*

Some sexually active teens thought abstinence messages from the media, parents, and friends were unrealistic and that those who said that they abstain are not telling the truth.

*“ What they mostly try to get across to teenagers is abstinence. And my point of view [is] that[ this] is really one-sided.”*

### **Drugs and alcohol and their effect on safer sex practices**

Drugs and alcohol are readily available and often used by teens. Most participants are at least drinking alcohol or smoking marijuana with some regularity, but several are also doing LSD (acid), “crank” (an amphetamine), crack (cocaine), and Ecstasy.

Having sex while drunk or stoned is also common practice among these participants. Some participants say it makes them less inhibited and it is fun, others say it makes them last longer, and some people claim not to remember much. Both males and females mentioned that girls may use “being high or drunk” as an excuse to have sex. Several male participants indicated that one way to get a girl was to get her high.

*“It's kind of fun you know.” (14 year old Native American female)*

*“Girls are not beyond judgment, they are just inebriated but they use it as an excuse...like 'oh I'm loaded'...” (18 year old Asian male)*

*“I have heard stories from parties of how people that are just friends and stuff that to me don't like each other very much and they are doing some really intimate things. So I see the effect of it [drugs or alcohol] sometimes. And the stories live on throughout the rest of the school year about these people or something just because of that one night that they got drunk. (16 year old white male)*

*“Like one night I got drunk and did it and I just felt like I had no respect for myself and I was cheap.” (15 year old white female)*

*“I just wish somebody was there and slapped me...I have one friend and I thank*

*her a lot of times because she has been there when I was drunk and just like pulled me out and said 'what are you doing'” (14 year old white female)*

Not being “taken advantage of” and “knowing real feelings” are some of the reasons participants chose not to be drunk or stoned while having sexual intercourse.

*“If you are drunk you can be taken advantage of because you have no idea what you are doing. You can never remember anything.” (14 year old white female)*

## Channels of communication

### *Sources of AIDS/STD information*

Participants are getting information from a variety of sources; schools, libraries, clinics, doctors, educated people, parents (mostly mothers) that they can trust, siblings, science teachers/counselors, movies/TV shows, and friends. Some participants mentioned that they would not rely on parents, who may want the youth to get tested and may ask too many questions. Many others depend on parents for information and advice. Teens often mention the importance of “credible” sources of information, implying or stating that they ignore information from unreliable sources. In terms of credibility, participants often state that they wouldn’t necessarily believe a friend their own age unless they had a direct experience with an STD or HIV.

*“Most of the stuff should come from adults or teachers and your mom and stuff. But like the stuff your friends tell you or people who are not entirely your friends you can’t really be sure of.” (14 year old white female)*

*“Usually in my group, I am the one they ask. Just because of my mom and the things she has taught me. And some of my friends go to my mom actually.” (15 year old African American female)*

The following is a list of specific media sources that focus group participants mentioned as having an impact and providing helpful information:

- From the media (television documentaries, realistic movies/videos, dramatic and to-the-point ads, news stories, idol or favorite star, magazines/books)
- Schools (libraries, counselors, nurses, teachers, classes)
- Parents (if informed and credible, and without pressure on teen)
- Friends (if trustworthy and non-biased)
- From an infected person of the same age group
- From an infected person in general (a person they know or a star)
- From explicit/scary/realistic descriptions

Few differences were noted by age, gender or ethnicity. Gay or bisexual males differed somewhat from their heterosexual peers when identifying sources of HIV/STD information. Many noted AIDS related agencies (e.g. the AIDS Foundation) as sources of information

about HIV while the heterosexual respondents were more likely to talk about teachers, health professionals and general information sources. This also may reflect recruitment, as all participants were recruited through a gay community center.

Participants had strong opinions on improving prevention messages. Most participants want to hear messages directly from the source “people who really have AIDS.” Many participants mentioned that it is best to relay information through similar age groups and lifestyles. The messages should be clear, to the point, and not talk down to the age group through acting or cartoons. Messages should show the “drama and consequences/ debilitation” of the disease. Repetitive messages were criticized.

*“Basically do it by giving realization to scare you. It is to show you that I could do unsafe sex once and this is what happened to me. You waste away and that is what is scary. Your body starts failing.” (16 year old white female)*

Most teens say hearing “true stories” about people like Magic Johnson or Easy E or seeing movies like *A Place For Annie*, *Kids* or *Philadelphia* made significant impact on their lives. They would like their favorite shows to have stories on AIDS acted out by their favorite stars.

*“I think a lot of messages like commercials we can’t relate to any of them. The people they have in commercials, the kind of activities they are doing, we can’t relate.” (17 year old male)*

*“You need to think about it, like I saw this lady on a talk show and she said just assume everybody you come in contact with has AIDS. . . that will make you cut down on who you have sex with.” (15 year old white female)*

*“I didn’t like the cartoons on AIDS. . . it was too unreal.” (17 year old white male)*

*“I think it is really frustrating when teachers and stuff try to beat around the bush. And they are trying to like not say how you really get it and everything like that. Because they really don’t want to talk about sex and everything. And I think it is irritating. (15 year old white female)*

*“And just like that movie, A Place for Annie. It just really made me cry, because there are so many irresponsible people out there that are having unsafe sex. I can say honestly I’ve had a lot of unsafe sex, but I get tested every six months. I stopped having unsafe sex, because I don’t want to catch it. I have goals and dreams I want to succeed in.” (Female)*

*“... have you seen the movie, Kids, that was just out? ... It was about a young teenager, a young group of kids in New York City, and these were real kids, in*

*fact, some of my friends know them. It's sad, because they are really like this, it was the environment that the kids were in and stuff. And this girl found out she had AIDS and it was from her first sexual experience with this kid that was sleeping around and thought he would sleep with virgins and he would be fine, and all this stuff. It was the scariest movie... I walked out and it's like my heart was beating and I thought I was going to, it was so scary. I had already made the decision to abstain. But this movie scared the hell out of everyone. I hate being scared, no one wants to be scared, but it works. It was good because we could relate to it. It was the same sort of scene that we hang out in. The party afterwards, then they had the subtle rape scene, she was passed out. They showed the girl screaming, and fighting him off, and it wasn't like that it was very subtle. It is much more common around, I know, kids my age. People don't consider it rape.. because she was passed out....It was a really good movie. ...But they wouldn't let minors see it. Made me really angry... You'd think the people they weren't letting in would be the people it would help the most. The people that were criticizing it were the parents. They go 'my kids don't do that, they should not be seeing this stuff.' But it's not true. It didn't glamorize drugs or anything,... everything looked so gross and disgusting and ugly. But it was, like, wow, that's what it really looks like the next morning. It looks that ugly and gross. It was not glamorizing. It was scary.” (18 year old female)*

*“I think there needs to be more like reality up in the messages. Not just repetitive things because then you just start blowing them off” (Male, 15-18).*

*"A lot of people are concentrating on 'Don't have sex, don't have sex, don't have sex,' when people aren't going to stop having sex. It should be 'Safe sex', not 'Don't have sex'." (18 year old female)*

## **Future aspirations**

When asked about the future, the most common responses were professional aspirations. Other future hopes expressed were to finish school and to have a family. Little difference was noted by gender, age, or ethnicity. Teens with aspirations for the future were more likely to be abstaining from sex. It is uncertain whether there was any association between future aspiration and consistent condom use.

# S

## *ummary of the homeless focus group*

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Most of the responses from participants in the “homeless” focus group are similar to the other focus groups. The following are some of the highlights:

- Nine out of 10 knew someone who has or had HIV/AIDS
- Respondents got information on HIV/STDs from relatives, planned parenthood, medical personnel, friends and pamphlets.
- Used some words for sex that were not mentioned in other groups: “tooky wookie” and “hubba hubba.”
- Were mixed about whether sex was just “sex” or “making love”

*“Making love is when you do it with passion and love not just wham bam thank you ma’am.” (14 year old white female)*

*“Kids don’t make love, they have sex.” (18 year old African American male)*

*“You can be going out with somebody for a few months, you are not making love but you are having sex because you can’t say you love that person.” (18 year old African American male)*

- Six participants say it is “bad” not to be exclusive with the person you are seeing

*“That is a shame.” (17 year old white female)*

*“That is a low down dirty thing.” (18 year old African American male)*

- Both males and females in this group were more mild about the extent they had to go to get their partner not to have sex

*“You can’t force them.” (15 year old white male)*

*“Why force the issue if you can just find somebody else” (14 year old Latina)*

- All but one participant uses drugs or alcohol when having sex

*“I always have sex when I’m loaded not no weed or anything but when I am*

*drunk and that's about it.” (18 year old white female)*

- Six out of 10 participants claim to use condoms. One African-American male and one Caucasian male admit to not using condoms.

*“You don't get the true feeling with a condom.” (18 year old African American male)*

- Two participants said they talk about using a condom with their partner

*“If we are going to be doing this, then you are just going to have to use a condom.” (17 year old white female)*

- They have the same complaints about using a condom, which include, “it rips,” “it doesn't fit,” it slows things down,” and “it slips off.”
- Hopes and dreams are similar but also more drastic, such as “Don't want to go to the pen,” and “want to win the lottery.”

# **S**ummary of parent focus groups and parent individual interviews

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## **HIV/AIDS knowledge**

Most of the parents had a good level of knowledge of HIV/AIDS. The focus group containing all female participants had a very interesting discussion about ethnicity and HIV education, and participants were very aware that ethnic minority communities have been significantly affected by the disease and neglected by service providers:

*“So everybody that I have seen that is getting help is not of the Afro/American, Latino and other minority groups.”*

However, there was confusion about testing and the window period, and about life expectancy after diagnosis.

## **Sexual behavior**

The acceptable age to start engaging in sexual activity varied widely. However, most of the parents seemed to believe that 16 to 18 years old was reasonable. *“Yeah, my expectation is 25. And my reality is 18.”* At the same time, they believed that most kids become sexually active at 12 or 13 years old. Many of the parents were aware of their children's sexual activities:

*“I know right now, he wants to be like his buddies and go and see, as he puts it, how many women he can fuck before he settles down. I don't care for it.”*

Many thought their children were not sexually active, especially the younger ones. Some parents believed that teens continued sexual activities “because it feels good” and because of “peer pressure sometimes.” However, several of the parents discussed sex as a means of feeling accepted or loved:

*“At that moment for them they feel close and that closeness is what is going to make them do it again. And the desire to have closeness.”*

## **Drug/alcohol use**

The majority of the parents believed that their kids had used or were using drugs and/or alcohol. The most common response was that they had tried alcohol.

*“I think they might have tasted a beer once in a while, just to see what it tastes like. Because I know my daughter said it tasted yuck.” (Individual interview, Caucasian father)*

*“I know my daughter has experimented, explored alcohol. Even in my presence she’s asked me about tasting the champagne or the mimosa or something like that.” (Individual interview, African American mother)*

They believed that kids in general start using alcohol/drugs at 12 or 13 years old or sometimes younger (one daughter started using marijuana at age nine). The extreme was expressed by one recovering-alcoholic mother who stated that her daughter drank heavily with her from the age of two to the age of four. Several participants had an addiction history and were quite knowledgeable about drug/alcohol issues.

### **Sources of information**

Parents mentioned the following as sex and/or drug information sources for teenagers:

- clinics
- media
- school
- peers
- someone who has been there
- printed material
- parents.

Most of the parents said they had discussed sex and/or drugs with their teenagers. However, some said they had not specifically discussed HIV and other STD prevention. Other parents not only discussed prevention, but provided condoms to their teens. Most of the parents felt they knew what their kids were doing, but felt that most other parents did not.

It was fairly unanimous that parents believed it is primarily the parents’ job to discuss sex and drug issues with kids, and secondarily the schools’ job.

*“I think a parent or parents, they just need to talk to their children. And anyway, I mean, if it's for drugs, if it's for sex, for anything, there is a need for*

*communication.” (Individual interview, Latina mother)*

Generally, the parents believed that printed materials, such as pamphlets, were ineffective. Some felt school programs were ineffective:

*“The instructors are not trained. They are, like ... a gym teacher or an English teacher that has to teach this segment. They don't have an educator or HIV educator teaching the class. And I think that is where they fail.” (Mother)*

This sentiment echoed many teens' requests for more realistic and accurate messages and appropriate message sources.

Another sentiment expressed by teens that was echoed by parents was the need for sex/ drug education to begin by sixth or seventh grade. Parents also felt that peers should be involved in education.

*“We underestimate just how mature young people are and how smart they are. How about asking them how to get the message across? Making [them] part of the solution rather than the focus of the problem?” (Individual interview, Caucasian mother).*

However, one parent pointed out that it is not just age dependent, it is important to know what stage of development the child is at:

*“I think that we should start at an age when the child feels, when a child asks a question, but we need to be sensitive to what that child really may be asking....a little three or four year old, whatever, asks ‘where do I come from?’, and you go through this grand explanation and all they wanted to know is... from me and your dad.” (African American mother)*

## **Condom availability**

Parents were generally in agreement that condoms should be more readily available and advertised publicly. One parent suggested that condom use is related to accessibility:

*“I think if it was easier to get them free, then they would be more likely to use them. And they could get them from a source, like maybe at their gym...just like girls buy their toiletries. At gyms and schools you could also put up a vending machine.” (Caucasian father)*

One mother said condoms should be advertised on radio and television “because that is what the masses are looking at, they're looking at TV, they're listening to the radio.” Another mother agreed with the idea of condom ads on television:

*“I’ve seen some commercials on HIV and condoms. I think they need to happen as often as feminine hygiene products’ [ads]. You can talk to me about Massengill, you ought to be able to talk to me about condoms. Perhaps I won’t need the Massengill.” (African American mother)*

Some of the parents had specific suggestions for HIV-prevention messages:

- Each type of high-school class could present information appropriate to its regular instruction: biology: T-cells and how HIV effects the immune system, experiments with rats to show how immune suppressing disease deteriorates the body, etc. (Individual interview, African-American mother)
- Messages should be ethnically appropriate. (Individual interview, Latina mother)
- Messages should be gender specific
- Develop a prevention video game: advancement earned by avoiding HIV; situations based on risk situations, e.g., you meet someone desirable, have no condoms, must go back three miles for a condom: what is your choice?
- Establish a 1-800 hotline for youth that answers: where is the nearest condom?

One parent succinctly stated what was an overwhelming undertone from the parents groups and interviews:

*“They listened and understood, but it’s, like, not real for them. Because they can’t see it happening to them. It’s like something off in the distance [that] may or may not happen. They’re smart, so it’s not going to happen to them, you know. Children have that type attitude.” (African American mother)*

# **A**ppendix A. *Project personnel*

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## **HIV Prevention Studies Group, Division of General Medicine, University of California at Davis**

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### **Staff Research Associate**

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### **Transcribers**

Joy Hansen

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### **Community service organizations**

*The following community service organizations provided enthusiastic support for the project, and space in which to conduct the focus groups:*

The Effort

Mending

Harm Reduction Services

Diogenes Youth Services

Loaves and Fishes

Lambda Community Center

John Jones Community Clinic  
Mexican-American Alcoholism Program

## **Prevention Marketing Initiative Sacramento Demonstration Site**

Kristen Weeks-Norton  
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## **Academy for Educational Development**

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Eileen Hanlon  
John Strand  
Carol Schechter  
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## **Porter/Novelli**

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## **Center for AIDS Prevention Studies, University of California-San Francisco**

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# **A**ppendix B. Discussion of focus group findings

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by Dr. Neil Flynn, Principal Investigator, HIV Prevention Studies,  
University of California, Davis

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*The following discussion was prepared by Dr. Neil Flynn, Principal Investigator of the focus group study. Because it provides interpretations that draw on data sources and analyses beyond the scope of the study, it is provided as an appendix to the main report. The discussion does not necessary represent the views of the entire research team.*

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## **Concept 1. Social relations, spare time activities, dating attitudes and behaviors, what's "cool"**

### *Discussion:*

Focus group respondents and individuals stated that they meet their friends in a variety of ways, including school, while hanging out, and through older siblings. They spend time with friends of either gender, usually the same age or older, but usually not with younger if this can be avoided. For the majority, friends were more important than boyfriends or girlfriends. Females, especially, reported spending time with older men, older boyfriends. Females also mentioned spending time with their families. Ethnicity of a friendship group can be mixed, though our impression is that this is more an attitude than a behavior.

Young gay men reported spending time with gay as well as "straight" friends in a school setting, but mostly with other gays in their spare time. They also reported socializing at the gay community center (however, this may simply reflect the fact that most of them were recruited from the gay community center). Homeless youth (recruited at a center serving homeless youth) spent a lot of time socializing and carrying out daily hygiene at the homeless youth center.

Getting drunk, high, "loaded" is a major pastime, across gender, age, ethnicity, and sexual experience lines, although proportionately more women's groups mentioned it than did men's groups. Another universal activity is 'hanging out' with a friend, watching videos, talking, listening to an eclectic mix of music, going to malls, i.e., "just kickin' it".

*Barriers to HIV risk-reduction:* Females hang out with (and have sex with) older males, increasing the risk of encountering an HIV-infected male. Young gay men avoid straight teens, perceive themselves to be marginalized, and may be more susceptible to entering a sexual relationship out of need of companionship. Young females also expressed that they would enter a sexual relationship in order to have companionship.

*Facilitators of risk reduction:* Appeal to the strong sense of belonging to a friendship group. Teens available for intervention at malls; listen to music frequently, and singers or groups are influential; teen centers reach “special” highest risk populations (homeless and young gay men).

## **Exploring “cool”**

### *Discussion:*

‘Cool’ and ‘uncool’ are powerful determinants of teen opinion. Being cool means acting in a way that attracts favorable attention of peers and entertains them — doing cool things, having an “attitude”, or style, that others in peer group find interesting, entertaining or funny. Cool can include fashion (baggy clothes; grunge dressing; brand clothes such as Adidas, Reebok, Polo and Timberland), music of several varieties (hip-hop, oldies, rap, R&B, techno), using cool language and body language. It may include going along with the crowd or it may be “doing your own thing” (individuality), depending on the circumstances. You can be cool within your own group, but being seen as uncool by members of other groups is also cool. There is a duality to adolescents’ thinking with respect to being cool by going along with the group, versus by being individualistic. They give lip service to being different and individualistic but, in reality, the “individualism” actually conforms to the “norms” within the group. For example, it is an individual thing, and cool, to have pink hair, but this is in the context of a group of peers who all dye their hair unusual colors. *“In my group we don’t really look for fads and stuff, we just wear whatever we want, really. We don’t copy anyone, we try to be originals. If other people are dyeing their hair green, then we want to dye it pink. It’s just that we want to be original.”* Pink is cool, and it is your own color, so you are being yourself, an individual, even though, in reality, you are doing what the group is doing. This attitude was present in many groups, but especially prominent among sexually active young females, and it crossed ethnic lines.

*Barriers to HIV risk-reduction:* Being drunk or high is a major barrier to HIV risk-reduction. It is seen as cool, and contributes to increased sexual activity and unsafe sexual activity. Hormonal activity is high in these teens. An ‘uncool’ risk-reduction message may be worse than none at all if teens associate it with the hoped-for change in behavior; i.e., if the message itself is uncool, then the behavior change being promoted, and the importance of AIDS, suffer by association with an ‘uncool’ message.

*Facilitators of risk-reduction:* Brand-name clothing manufacturers have teens’ attention. Music is very important to teens — messages in this medium may be listened to. Being different (in the context of being part of the group) and being ‘cool’ may be potential focal points for risk-reduction messages.

## **Dating attitudes and behaviors**

### *Discussion:*

Males and females, all ages, say friendships are very important. If you have a girlfriend or boyfriend, it's "cool" but there isn't much stigma attached to not having one, and most do not feel pressured to have one. Males say a girlfriend is important for sexual activity. This male sentiment was acknowledged by females. Males like to have more than one girlfriend. Females like to spend time with boyfriend — shared interests, trust him, feel good with him. Those teens who said it was very important to have a girlfriend/boyfriend often reported that s(he) helped to fill an emotional void. This sentiment was expressed by younger females and by gay male teens.

*Barriers to risk reduction:* Relationships don't last very long, leading to multiple partners over time; young women and gay males express a need for companionship, which leads them to participating in sexual activity if that is what is required for maintaining the relationship.

*Facilitators of risk-reduction include:* Lack of stigma attached to not having boyfriend/girlfriend; friendship is the most important relationship; desire for emotional connection, stronger in young women and gay teens than in young heterosexual men, if channeled into non-sexual relationships.

## **Concept 2. HIV knowledge, information sources, susceptibility beliefs, ways to reach youth with the HIV-prevention message**

### *Discussion:*

The most commonly mentioned sources of HIV information were parents, the media (mostly TV), people with AIDS, particularly well-known people with AIDS, school (favorite teachers, and health education classes), doctor, and posters. Some of the messages were perceived as very good, but suffered from repetition. Teens wanted variety. However, the quality of much of the prevention messages was rated as poor. According to our respondents, the best messages are 'catchy', cute and entertaining, feature young people themselves, especially young people with HIV infection, graphic, culturally (male/female, ethnicity, age) relevant, and give the facts, but do not overdramatize.

## **Susceptibility beliefs**

### *Discussion:*

We observed a curious, but well-known, phenomenon with respect to the belief in personal risk for acquiring HIV infection, across all segmentation variables. Addressing this phenomenon will be critical to changing high-risk behavior. While respondents were aware of the ways in which

HIV is transmitted, are aware that people just like themselves have HIV infection, and are aware that their own behaviors are the type that resulted in transmission, they did not conclude that they are personally at risk each time they engage in the behavior. Nor did they consider that they might already be infected. The analogy that occurs to me is that of trying to bring the same poles of two magnets together — the closer they are brought together the more forcefully they push apart.

There are a number of psychological benefits to this refusal to make the connection, of course. One can avoid the anxiety of thinking that one may already be infected. One doesn't have to re-examine a pleasurable behavior and admit that it might come with enough thorns attached that the behavior needs to be modified to what is perceived to be a less pleasurable one. It seems evident that the teens we interviewed have not really internalized a belief in personal risk. Intellectually, teens are aware of what behaviors are high risk, yet many seem to have that sense of personal invulnerability — “It won't happen to me.” This, despite the fact that many report knowing someone who has or had HIV/AIDS. Of those who did seem to have a true sense of personal risk, most know, or had known, someone in their personal lives who was/is infected with the virus, not just about someone like Easy E [the popular rap artist who died of AIDS]. When respondents tell us that they want graphic detail, perhaps they are telling us to keep trying to break down this wall of denial — perhaps they are aware of their own resistance against coming to an unwelcome conclusion. Discussion of the fear of pregnancy, which outweighed the fear of HIV in most of the groups, is also illustrative of the failure of knowledge to be translated into behavior, given Sacramento's high teen pregnancy rate. While internalization of a belief in personal susceptibility is necessary for behavior change, it is not sufficient.

*Barriers to HIV risk-reduction:* A major barrier to risk reduction is the resistance teens have to personalizing risk to themselves. They find it very difficult to believe that “it could happen to me.” Internalizing this belief will be a necessary component to behavior change.

*Facilitators of risk-reduction:* Knowing someone with HIV/AIDS came up repeatedly as a strong *predictor* for belief in susceptibility. Therefore, the more people they know personally who have HIV/AIDS, the more likely they are to believe “it can happen to me.”

### **Concept 3. Sexual attitudes and behavior**

#### **Definition of sex**

##### *Discussion:*

As expected, sex occupies a place of prominence in teens' thoughts and behaviors. To heterosexual teens the word 'sex' means penetrative sexual intercourse, along with more than 40 other terms for intercourse offered by focus group participants. Some gay teens considered mutual masturbation as equivalent to intercourse. The majority of teens interviewed had had

intercourse — many with more than one partner. Most of these claimed to have tried condoms at least once, but regular condom use was the exception.

Many teens say they know teens who do not engage in sexual activity. *“A lot of, you know, women these days at my school, I know a lot of girls, they are all virgins. They don’t go out and have sex. And they are waiting to get married.”* However, it appears that, once sexual activity has commenced, *“...there is no going back.”* This concept was expressed by both genders, across age and ethnicity groups. The exception to this belief was expressed by young women who were either currently pregnant, or who already had children. *“My sister has got a baby but she don’t have sex. It is like she is a reborn virgin.”*

Sexual intercourse is often casual. Both males and females expressed this value. There is still more stigma attached to promiscuity by females than by males. Sex is not synonymous with “making love.” Making love implies a deeper emotional involvement. (*“Making love is special for someone.”*) This sentiment was universal, crossing gender, age, and ethnic boundaries. There is a moderate consensus that a really satisfying relationship would involve emotional involvement, as well as sex. This does not seem to reduce the strength of the attraction of casual sex, however *“When you have a one-night stand it is just like another thing to do”* and *“...peace, love, and just a friendly fuck...”*

Fidelity is valued in a sexual relationship, by both males and females. It is considered a form of disease prevention— *“That is why you find someone that won’t cheat. You definitely find someone that you know won’t cheat.”* This concept is integrated with the concept of serial monogamy. Monogamy implies some months (most common was approximately six to eight months) of exclusive sexual partnering. Sex outside of this relatively ‘long-term’ relationship during this period is considered poor form and reason for anger, by both males and females.

Among teens who have not had intercourse, a few had merely avoided penile penetrative sex. Others gave reasons for avoiding intercourse, chief among these being fear of pregnancy. *“Abstinence — not the easiest way, but definitely the best.”* This was a stronger motivator than fear of STDs. (Fear of pregnancy may provide a rationale for a stronger desire to use condoms, as well as a reason for avoiding intercourse.) Other reasons for not having intercourse were: not having met the right person, lack of opportunity, fear of discovery, not wanting to bring intercourse into a relationship, and spiritual/moral beliefs which condemn such behavior outside of marriage. The latter was a distinctly minority opinion among the teens we interviewed.

Many sexually active teens understood that there could be benefits (other than HIV prevention) to remaining sexually abstinent, such as not contracting other STDs; no pregnancy; increased self respect; better overall health; a sense of goal achievement; ability to party more; longer relationships; more trust in relationships; improved loyalty; and keeps the fantasy (of sex) stronger. *“There would be less talk around town and there would be less people dying and catching things.”* Ironically, two-thirds of the members of these groups had had several sexual

partners in their lifetime.

Many of the female focus groups expressed an awareness of (and some had experience with) forced sex and dangerous situations, yet, none of the males expressed even an awareness of these types of situations.

*Barriers to risk reduction:* Belief that once you have engaged in sexual activity, it is not an option to choose celibacy. Concept of serial monogamy still allows for many sexual partners over a relatively short time period. Willingness to engage in casual sex.

*Facilitators of risk reduction:* Belief that sexual fidelity is important. Apparent acceptance, even praise, for those who choose abstinence. A positive perception of people who make behavior changes purposefully for risk reduction.

### **Drug use related to sexual behavior**

#### *Discussion:*

Alcohol and other drug use is nearly ubiquitous in the population we studied. Eighty-four percent reported alcohol use in their lifetime, and 75% reported drinking in the six months prior to interview. Sixty-three percent reported marijuana use in their life time, and 58% reported smoking pot in the six months prior to interview. The majority of teens we interviewed used alcohol and marijuana on a regular basis, often to excess, and considered it normal, even desired, behavior (“When you are drinking, you are always cool”). Alcohol and drugs are used for relaxation, improving the chances of having sex (“*It gives me the confidence to get any girl. I’ll talk to them and it usually works. If I have wine it really puts me in the mood for love...*” and “*...cocaine makes women horny*”), and excusing what happened the night before (“*...I’m not worried about it [AIDS] ’cause I know how to protect myself from it, except when those beer goggles are on [laughs]*” and “*People tend to take advantage of you when you are high or drunk*”).

Attitudes toward mixing sex and drugs were generally positive. “*Sex feels better when you are high*” and “*You ain’t never had no kind of sex until you had sex on acid*”. When pressed to justify using alcohol to excuse sexual behavior they felt uncomfortable about, many teens admitted that it is not a legitimate excuse, but it works. Having sex ‘under the influence’ helps to preserve self-respect — the ‘I couldn’t help myself’ argument.

Several groups of males admitted to consciously using peer pressure to get females to use drugs/ alcohol in order to obtain sex. “*Slip ’em something*” and “[when drunk] *I think I am the best looking guy in the world. And I don’t care... get her in the back room. And if she was drunk it would be hella easy.*”

In comparison with alcohol and marijuana, there was a relatively small amount of stimulant drug

use, such as cocaine and methamphetamine. ‘Only’ 25% of teens reported drug use other than alcohol or marijuana in the six months prior to interview. More than half (54%) of these teens reported using methamphetamine, and 46% reported hallucinogen use (predominantly Ecstasy and LSD). These drugs were generally condemned as not cool: *“Everyone told me crank was cool. I overdosed on crank, I hallucinated and all it’s really done is messed. I lost a big chunk of my life.”* *“And you know what, crank is not really cool. People are starting to think it’s cool.”*

*Barriers to risk reduction:* Alcohol and marijuana are major barriers to abstinence or safer sex. They not only lower inhibitions to having sex (which many males felt was a plus), but act as a convenient excuse later for regrettable behavior. Drug use and unsafe sexual activity are faithful companions. Abstinence or safer sex are, to a large extent, dependent on dealing with the problem of alcohol and marijuana use in this population. This research confirms that the problem of HIV transmission cannot be separated from the problem of alcohol/drug use.

*Facilitators of risk reduction:* Negative perceptions of mixing alcohol/drugs with sex. Realization that using alcohol/drug use as an excuse for engaging in unsafe sexual activity is not acceptable.

## **Concept 5. Safer sex**

### *Discussion:*

Abstinence is seen as desirable by some, particularly those who have definite goals, such as college, career, etc. It is not viewed negatively, at least by the time teens have reached high school. It is seen as a valid individual choice. It is acknowledged as the only sure way to avoid pregnancy and STDs. But the majority of the teens we interviewed were sexually active, in keeping with our objective of recruiting such young people. Returning to abstinence after being sexually active was felt to be unlikely, and not an attractive option, by those who have been sexually active.

Participants had good basic technical knowledge regarding condoms (i.e., latex condoms superior to natural, all condoms can leak). There was a range of confidence in ability of condoms to prevent pregnancy and STDs (one extreme was represented by FG 13—they believed that women poke holes in condoms so they can get pregnant and “trap” a man into a relationship). A few respondents quoted that they had heard that condoms “weren’t all that good,” but could not say how good they are. There was very little knowledge about lubrication and lubricants.

Practically all the groups expressed a positive perception of regular condom use and some females expressed negative judgements about males who do not wear condoms (*“There are some guys out there that just think they are all that and they don’t need to have a condom on because they are just so fine and a condom ain’t the same and blah, blah,*

*blah.*”). However, there is a perceived norm among teens that people say they use condoms consistently, but they really do not. Many respondents said that they had tried condoms, but that they had not continued using them. Why don’t they continue to use condoms? There are a litany of negatives regarding condom use offered, but our sense is that embarrassment about talking about them, because talking about them implies that you want to have sex with that person, embarrassment about putting one on, and interruption of the passionate moment (because of lack of skill in using one?) are the strongest barriers to condom use. In addition, use of one might imply that one or other of the partners is “dirty”, or is more sexually experienced than (s)he would like to admit. Also, use of one might imply distrust, a feeling antithetical to the moment. Additionally, lack of availability, due to cost and embarrassment in buying them, and discomfort or breakage/leakage, due to improper use, also contribute to trying them once and not using them again. Finally, many teens say sex is often “unplanned.” The males in one group believed that females usually plan to engage in sexual activity and just say they don’t. Teens also rationalize not using condoms because they don’t always work, so why bother?

At least one teen suggested “peer distribution” as a method: having trained teens distribute condoms and information at locations where teens are likely to be found (malls, movies, parks, etc.).

Teens demonstrated a lack of knowledge about technical aspects of using condoms. They repeatedly glossed over details in condom use that these investigators know can make the difference between comfort and pain, success and failure, and breakage/no breakage. They have virtually no knowledge of proper lubrication. They had not received careful, “hands on” instruction in proper use of condoms. Several groups mentioned that there is minimal discussion about condom use in social situations: “*So, I mean, I think I asked my friends once ‘do you know how to put one [condom] on?’ , you know, and they’re like, well yeah, yeah, what are you talking about’ and they just change the subject. I really don’t think they do*” and that it is not OK to discuss condom use with your sexual partner. The latter was expressed mostly by females.

*Barriers to risk reduction:* Lack of knowledge (and convenient, trusted sources of information) regarding the technical aspects of how to use a condom. Misperception that condoms are not as effective as they really are (>99% when used properly). Lack of practice putting one on properly. Difficulty accessing/acquiring condoms. Contradictory images: positive for reported consistent condom use; negative for the reality of possessing a condom, discussing condom use, introducing one into foreplay. Fear that condom use would imply lack of trust or thinking that your partner is dirty. Cost of condoms is mentioned as a barrier to purchase.

*Facilitators of risk reduction:* Positive perception of consistent condom users. Perceived benefits of regular condom use: primarily, decreased risk of pregnancy when not on birth control; secondarily, STD prevention.

## Conclusions

This formative research for the Prevention Marketing Initiative was an eye-opener for some of us on the research team. We all had a vague idea of the mind-set, behaviors, and social norms in our adolescent target population, with respect to their HIV and AIDS risk (MMWR March 24, 1995); but I doubt that many of us understood the degree to which they actually engage in high-risk behaviors, and their profound apparent inability to translate their knowledge of HIV/AIDS risk into safer behavior. Knowledge and their desire to protect themselves exist on a plane quite separate from that of their emotions and behavior. They are quite clear that their age group is at risk for HIV, but resist the conclusion that, therefore, “I am at risk”. It is clear that the task of the PMI is to find ways of linking these two planes more strongly so that behavior more closely mirrors knowledge and belief.

What did the young people we interviewed tell us about themselves and their concerns? What clues did they give us that might assist us in making HIV prevention more attractive to them? What do they not want to hear or see? What will turn them off? How did the parents we interviewed feel about their children’s risk?

Several themes surfaced repeatedly. These young people express a desire to ‘be themselves’, and they value the perception that they are engaging in independent thinking and action. They emphasized that, while they are susceptible to peer pressure, they also feel free to deviate from their peer group norms when they choose to. They expressed the perception that such tolerance of individualism was, itself, a peer “norm”. However, we were left with the impression that being different meant being different within the norms of the peer group. For example, they like to wear clothes that are different, but only within the context that dressing differently is a peer norm. They valued “being cool” a great deal, and this exerted influence on their behavior. They were vague about what “being cool” entails, but “knew it when they saw it.” The plethora of terms used to refer to “cool” is a reflection of their concern with the concept.

They placed a high value on ‘respect’ — getting it and giving it. It was most often used in the context of how others treated them superficially — gestures, taunts, etc. This concept was interwoven with their identification with their friendship group. It was often used in the context of banding together when a member of the group did not “get respect” from someone outside the group, i.e., someone had been “disrespectful” to a member of the group. At other times the word was used in a more traditional sense, such as respect for one’s self or for others and their ideas.

Their attitudes toward HIV risk behaviors, and people who engage in them, were relatively non-judgmental. Toward those who have unprotected intercourse, their attitude could best be summarized with the phrase, “That’s cool”; and of those who abstain, “That’s cool, too.” There is a strong undercurrent of respect for those who are able to abstain, but not a corresponding critical judgement upon those who partake.

As one would expect, sexuality is quite important to people in this age group. Those who have experienced intercourse expressed that they wanted more. There was no going back to abstinence for most of them. One of their greatest concerns about intercourse was the problem of pregnancy. The fear of pregnancy was among the most frequently mentioned complications of sexual activity. It was of major concern to young men and young women alike. Because of the frequency and immediacy of pregnancy, and their relative lack of experience with HIV/AIDS, concerns about pregnancy often appeared to eclipse concern for HIV.

Sexual activity is often unplanned — “it just happens.” Alcohol/drugs, as discussed above, can help it happen. Most commonly it (sex) “happens” at home, or at the home of a friend. The fear of getting caught in the act was raised frequently, usually accompanied by a chorus of giggling and laughter. Couples parties were cited as frequent venues for sexual activity. Often there is not a condom readily available.

Both alcohol/drug use and sexual activity were pervasive among these young people. They were facts of life, givens, no big deal. The majority had experience with both. They described regular alcohol and marijuana use, but those who had tried stimulants such as cocaine or methamphetamine, or hallucinogens such as LSD or Ecstasy were a relatively small minority. Interestingly, they were ambivalent toward the mixing of alcohol/drugs with sex: many said it was a way of facilitating sex, and some embraced it for that reason. But most felt that alcohol/drug use was not really a legitimate excuse for having had sex, when feeling remorseful about it later. In other words, even though they used alcohol/drugs to make sex more likely to happen, and seemed to make the experience more pleasurable, the use did not serve as an excuse for doing something which they later regretted. This ambivalence suggests that a complex relationship exists between these young people and alcohol/drugs. There is recognition, at least on a cognitive level, of the role of personal responsibility for their actions which could not be abrogated simply by blaming behavior on an external force. Yet alcohol/drugs served a useful and, in their view, legitimate function in getting what they wanted - sexual activity. These sentiments crossed gender, intelligence, social, and group boundaries.

Young women frequently distinguished between having sex and making love. They attributed more emotional involvement to making love. This was not a frequent sentiment among young men. In addition, some young women expressed an awareness of dangerous sexual situations, where coercion and/or the threat of violence exist. Some of the young women even discussed their personal experience with sexual violence, which included date rape and molest by family members. None of the young men mentioned this issue.

The issue of condoms and their use appears to be a complex one. Most teens expressed respect for those who use them all the time, yet most did not believe that anyone really used them all the time. This sentiment crossed gender boundaries. Most of those who had experienced intercourse had tried them, and some did not like them. They expressed a number of criticisms of condoms, including that their use interrupts the mood, they are a hassle to use, and it is embarrassing to buy or use one. And yet, they felt that condoms were “easy” to use.

We were left with the impression that the concept of their use is an easy one for teens to grasp, but that teens do not acknowledge the practical difficulties in their use, even after enumerating them. They seemed reluctant to acknowledge that there might be an art to the use of condoms. They generally do not discuss condom use or techniques with each other, or with a potential sexual partner. To discuss condoms with a potential sexual partner would be to bring the issue of having sex out into the cold light of day, where it might be rejected. It would be less risky to just “let sex happen.” Responsibility for the use of condoms was not accepted by either the young women or the young men. There is no convention regarding responsibility for condom use by a couple.

# **A**ppendix C. *What experts say about young men who have sex with men*

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*The following are excerpts from a memo drafted by Dr. Olga Grinstead of the Center for AIDS Prevention Studies (CAPS), University of California-San Francisco, to the Sacramento Design Team.*

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As we discussed at our meeting in Washington on January 24, I have reviewed the focus group and individual interview tapes and transcripts, interviewed several individuals who are doing research in this area and conducted a computerized literature search guided by their suggestions. I have included here a summary of those discussions.

As I started looking into this, however, it became clear that there are several distinct populations included in the group ‘young males who have sex with males’ that we were discussing. First, there are the very young men (14-18 or so) who are just starting to experiment with sex and may be having sex with other young men or older men but do not identify as gay (yet). Then there are the very young men (14-18 or so) who are already gay identified and coming out (we heard from some of them in the Lambda House focus group) and the ones that are going through this process a bit later (say 18-21 or so). It might be useful to reconsider which of these groups we might be trying to reach in PMI-their risk needs are likely to be different.

I spoke with Bob Hays, Susan Kegeles and Maria Ekstrand here at CAPS. They all agreed that there is very little written about very young males who are having sex with males (YMSMs). When they refer to ‘young gay men’ they mean 18-29 year olds; they describe the 14-18 year olds as ‘gay/bisexual youth’. I also interviewed some service providers at the Stop AIDS Project here in San Francisco. Each of them said that most of the research on gay/bisexual youth has been conducted in the context of runaway and/or homeless youth. Susan Kegeles was more willing to conjecture that the very young men will be very much like their heterosexual counterparts. They will have poor communication skills regarding condoms and little ability to negotiate safe condom use, they will have particular difficulty negotiating condom use in a boyfriend relationship because of issues of trust and love and they will have low perceived risk of HIV and other STDs (especially if they are having sex with other young men as opposed to older men). Susan also noted that when young gay men in their studies talk about their coming out years, they usually describe moving from less risky behaviors (e.g. mutual masturbation) to more risky behaviors through their teen years [unless of course they are having to sell sex]. This is reassuring because it suggests that the very young men may not be engaging in the riskiest behaviors.

Dan Wohlfeiler at the Stop AIDS Project summed it up by saying that young men who have sex with men in this age group (under 18) are a lot more similar to any other adolescents in terms of their condom barriers than they are similar to adult gay men.

We could pursue a number of leads regarding gay youth (specialists and publications), but my opinion, however, is that this would be getting a bit far off track. We are not going to direct an intervention only to very young males having sex with males [it is too small an audience, too hidden and it is too political], and I think there is enough overlap in condom barriers just with the issue of trust and being risky within boyfriend relationships to make a bridge with heterosexual teens.

# **A** *ppendix D: Research instruments*

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**Youth consent form**

**Adult consent form**

**Pledge of confidentiality**

**Adolescent focus group screening questionnaire**

**Adolescent focus group guide**

**Parent/adult gatekeeper demographic questionnaire**

**Parent focus group guide**

**Guide for individual interviews**