“Here’s What I’d Do . . . ”: Condom Promotion Strategies Proposed by High-Risk Women in Anchorage, Alaska

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Women drug users are at significant risk of sexually transmitted HIV; however, interventions aimed at increasing condom use by this population have been relatively ineffective. The authors conducted a series of focus groups with 17 current and former drug-using women to identify (a) reasons for using versus not using condoms, (b) intervention strategies they believed would be most effective at increasing condom use, and (c) previous ineffective intervention strategies. Risk of HIV, sexually transmitted diseases, and pregnancy was the main reason given for using condoms. Many factors were identified that limited condom use, including lack of availability, substance use, and cost. Participants enthusiastically endorsed condom availability and AIDS awareness interventions, and suggested that no intervention was a waste of money. The authors discuss the limitations of the suggested interventions and recommend additional research to evaluate the efficacy of these strategies.

Keywords: *condom promotion strategies; use interventions; human immunodeficiency virus; acquired immunodeficiency syndrome; STDs; drug-using women; qualitative needs assessment*

Despite hopes that we have already witnessed the worst of the HIV/AIDS epidemic, it appears to be still in its early stages (Piot, 2002). The proportion of AIDS cases representing women is much larger than earlier in the epidemic (Centers for Disease Control [CDC], 2001a; 2001b). Among both men and women, drug use continues to play a role in risky sexual behavior (Inciardi, 1995; Kim, Marmor, Dubin, & Wolfe, 1993; Lewis & Watters, 1994; M. Williams et al., 2001). In addition, women who use drugs face the increased likelihood (relative to male drug users) of having a high-risk sexual partner. Injection drug users (IDUs), who are at increased risk due to the sharing of injection equipment (Chitwood et al., 1995), are more likely to be men than women (Des Jarlais, Chamberland, Yancovitz, Weinberg, & Friedman, 1984). Due in part to this imbalance, female IDUs are more likely than their male counterparts to have a sexual partner who also injects (Des Jarlais et al.,

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1984). Moreover, male IDUs have been found to use condoms especially infrequently with female IDU sex partners (Freeman, Rodriguez, & French, 1994), compounding the risk of exposure faced by drug-using women.

To control the further spread of HIV/AIDS and other sexually transmitted diseases (STDs), it will be crucial to develop, implement, and maintain preventive interventions aimed at increasing condom use among at-risk persons (CDC, 1996), such as drug-using women. Because condoms have been shown to be effective in preventing transmission of HIV (Davis & Weller, 1999; European Study Group on Heterosexual Transmission of HIV, 1992) as well as hepatitis B and other STDs (Minuk et al., 1987; Sanchez et al., 1998), the Public Health Service has recommended consistent and correct use of condoms as a means to reduce HIV risk (CDC, 1986).

To date, many researchers have examined the effectiveness of interventions aimed at reducing the sexual-risk behaviors of drug users. In general, the majority has had limited, inconsistent, or no effect on sexual-risk behavior (Cottler et al., 1998; Donoghoe, Stimson, Dolan, & Alldritt, 1989; Higgins et al., 1991; Kotranski et al., 1998; Rhodes, Stimson, & Quirk, 1996). Condom use in particular appears to be harder to change than other sexual-risk behaviors, such as having multiple sexual partners (Cottler et al., 1998). It is unclear why condom use interventions have had such limited success; however, one criticism of traditional research and intervention approaches is that they do not involve the targeted community members in the development phase, with the resultant decontextualizing of the information used in their programs (Schulz, Krieger, & Galea, 2002). Recently, there has been a call to incorporate the community perspective into the development of HIV preventive programs to enhance their relevance for the affected communities (Auerbach & Coates, 2000). Indeed, community-based approaches might be especially effective for marginalized social groups (Isreal, Schulz, Parker, & Becker, 1998), such as drug users.

Focus groups and other qualitative methods might be ideal ways to gain this community insight. Ethnographic methods have increasingly been used to understand the context in which risk behavior occurs, potentially informing the development of more effective HIV/AIDS interventions (Parker & Ehrhardt, 2001). Focus groups might also be particularly suited to collecting information on sensitive subjects, such as sexual behavior (Basch, 1987). In the current study, we conducted a series of focus groups with former drug-using women to identify their perceived needs regarding condom promotion interventions. Secondarily, we asked focus group participants to identify (a) reasons condoms are used versus not used and (b) unsuccessful past condom promotion strategies.

METHOD

Recruitment

This study was completed as part of a larger, National Institutes on Drug Abuse–funded study of condom use among drug-using women in Anchorage, Alaska (N = 262). All women who had participated in the larger, mostly quantitative study were eligible for participation in the focus group study described in this article. Recruit-

ment procedures for the larger study have been described elsewhere (Fenaughty, 2003) and will be summarized here briefly. We collected quantitative data between November 1997 and July 1999 from adult women who (a) self-reported and produced evidence of recent (within 30 days) drug use via positive urinalysis for cocaine metabolites, morphine, or amphetamines, and/or showed evidence of recent injection; and (b) self-reported having had sexual intercourse within the 30 days prior to interview. We recruited the drug-using women from the streets of Anchorage using a combination of targeted (Watters & Biernacki, 1989) and snowball sampling (Biernacki & Waldorf, 1981). Few of the women (4%) reported having been in drug treatment in the previous month, making this a largely out-of-treatment sample.

We conducted five focus groups of between 2 and 6 women each (n = 17) between February and May 2002. We collected no additional quantitative drug use data at the time of focus group participation, so there is no way to be certain of the current drug-using status of the participants. In fact, several women volunteered information during the focus groups indicating they were no longer using drugs. However, even if some were no longer currently using drugs, all of the women had reported using drugs within the past 5 years and were more likely than women who had never used drugs to relapse to drug use and thus increase their risk of exposure to HIV and other STDs. Furthermore, regardless of current drug use, all the women had once lived a relatively risky life by virtue of their past drug use and would certainly be considered relevant and valuable sources of information on the design of preventive interventions targeted at female drug users.

We informed all 262 women participating in the larger study at the time of interview that they would have the opportunity to participate in a focus group study at a later time. At that time, we asked them for detailed contact tracing information, and they gave informed consent for participation in both the quantitative and later qualitative studies using a form approved by the University of Alaska Anchorage's Institutional Review Board. After the quantitative portion of the study was complete, a random list of participants served as the sampling frame for the focus group study. We recruited potential participants by phone, using the contact tracing information provided 2 to 4 years earlier. A large percentage of the phone numbers were no longer valid, which is not surprising given the transient nature of the cohort and the length of time between studies. We therefore mailed out requests for participant-initiated contact to the best available addresses. In this manner, recruitment continued, and we conducted focus groups until saturation had occurred.

Focus Group Methodology

The focus groups were conducted by a female licensed clinical psychologist with extensive experience both in working with drug-using women and in facilitating focus groups. Each focus group was audiotaped by a female cofacilitator. Given the sensitive nature of the topics, it was deemed important to use same-gender facilitators to encourage as open and comfortable a discussion as possible. The focus groups, which were held in one of two private conference rooms, lasted approximately 90 minutes, and refreshments were provided.

At the beginning of each group, the facilitator described the purpose of the focus groups and the discussion guidelines, including confidentiality, courtesy, and

honesty. She told participants that we were interested in hearing about their ideas on condom use, specifically (a) reasons people do or do not use condoms, (b) ideas for successful condom use interventions, and (c) suggestions about past or current unsuccessful condom use interventions. The facilitator used these three main probes as an outline for the discussion; additional probes were added as demanded by participant responses or based on information we received from previous focus groups. Throughout each group, the facilitator frequently summarized the participants' comments, to provide opportunities for them to clarify their points. Typically, participants' attention and the discussion points were exhausted simultaneously, signaling the end of the focus group. The women were thanked, paid U.S.$25 as compensation for their time, and offered bus tokens for their trip home.

Data Analysis

We transcribed the audiotapes verbatim, then coded and analyzed them using The Ethnograph software. We coded the transcripts for thematic content using standard ethnographic practices (Krueger, 1998). Coding and analysis was an iterative process in which data were used from the following sources: (a) notes on facilitator debriefings following each group, (b) notes taken by the cofacilitator during each group, and (c) verbatim transcripts of each focus group. We identified concepts as themes if they were expressed with frequency, extensiveness, or intensity (Krueger, 1998). As new themes emerged, we recoded previously coded transcripts to include the newer themes. This process continued until no new themes emerged.

RESULTS

In Table 1, we have shown selected demographic characteristics of the sample, as well as participants' drug use at time of initial interview, 2 to 4 years prior to focus group participation, and history of trading sex for drugs or money. Speakers are identified with fictional names. In addition, because prostitution and drug use so often permeated participants' discussions of condom use and interventions, speakers are identified as former injection drug users (IDU) if they had injected drugs in addition to smoking crack and as former sex workers if they had ever traded sex for money or drugs. As previously noted, these labels reflect former behavior and experiences, and might not be indicative of the participant's current lifestyle.

Reasons for Condom Use Versus Non-Use

The majority of the women were in agreement that condoms are used to protect oneself from risk of pregnancy, AIDS, and other STDs. Many of the women reported using condoms for disease prevention. Helen, a former IDU and sex worker, stated,

> Why I started using condoms is—again not to point out—that when you have sex with somebody, you're not only having sex with them. You're having sex with everybody. You're having sex with not just with the partner, but you're having sex with everybody that they had sex with. And so—Eeeeewwwww!

TABLE 1: Sample Demographics, History of Drug Use, and History of Trading Sex for Drugs or Money (N = 17)

Characteristic	*Number of Participants (n)*	*Percent*
Ethnicity		
African American	4	24
American Indian/Alaska Native	4	24
Caucasian	9	53
Used crack[a]	17	100
Used cocaine (injected, snorted)	9	53
Used heroin	1	6
Injected any drug	8	47
Traded sex for drugs, ever	12	71
Traded sex for money, ever	15	88

NOTE: The average age of participants was 41.18 years (S.D. = 6.12).
a. Self-reported and urinalysis-confirmed drug use in 30 days prior to initial interview, 2 to 4 years before focus group.

When asked about reasons for using condoms, many of the women immediately began talking about "working girls," or prostitutes. In fact, a few women indicated that being a prostitute was itself a reason for using a condom. Many suggested that prostitutes use condoms all the time and offered that they personally used condoms consistently when they were "on the streets," often at the risk of losing the trick.

Although protection from diseases was the main incentive for using condoms, protection from pregnancy was also mentioned by several women, especially when referring to their own children or to teenagers in general. Phyllis, a mother of two, said,

> I have taught them the importance of using condoms and why, you know? You're young, you don't need kids, be getting stuck in a relationship because you're pregnant. You know, you take, you take, um, measures. Condoms. That's a measure for your protection and for your partner's protection.

Reasons given for not using condoms were more varied, including lack of availability, the influence of drugs and alcohol, cost, difficulty in use, embarrassment, low perceived risk of partner, and carelessness. The theme of condom availability was a consistent one throughout each focus group:

> Using a condom is the same thing about using a dirty needle, you know? You have access to, if you're a junky, and you got access to a brand new needle, you're gonna use that needle way before you use an old one. You know? And the choice is, if you have a condom, you have a choice whether you're going to use it or not, you know? If you don't have a condom you don't have that choice. (Helen, former IDU and sex worker)

Although, as noted earlier, prostitutes were often singled out as being more likely than others to use condoms consistently, there was also considerable discussion about the negative effects of both substance use and lack of availability on condom use, particularly as it related to safe sex among prostitutes:

> I believe that most of the girls that's out there working the streets are doing it for drugs. 'Cause I can't see . . . that's what I did it for. . . . But, uh, the drugs make you do a lot of things, and hurt the ones you love. And, you know, and, that if you didn't have a condom, then just go ahead and, you know. (Janice, former IDU and sex worker)

Several women indicated that the financial cost of condoms might keep them or others from buying them, and a few women suggested that difficulty in using condoms might limit their use somewhat. Embarrassment was also suggested as a possible reason for low condom use. It was believed that some, particularly teenagers, would be embarrassed by the prospect of having to buy a condom or by the reality of not having enough money to buy condoms. Other women admitted they would be embarrassed to introduce using a condom to their partner:

> I would use a condom, but it would be embarrassing for me to do it. . . . I would take some condoms. But getting down to the nitty gritty, where I'm strippin' and he's strippin', and you go, "Hey, um . . . " (Karen, a former IDU)

Perceptions of the sexual partner's risk appeared to play a big role in decisions to not use condoms. Although almost all the women were proponents of condom use in general, many were not using condoms currently, because they were with a "steady" partner and believed this reduced to acceptable limits the chances of their catching a disease:

> Yeah, I'm in the same type of relationship where I know he doesn't go out on me. I don't go out on him, so thank goodness. And I can't have kids, so . . . so I feel pretty safe without having to use [condoms]. (Florence, former IDU and sex worker)

However, almost every one of the women who said they did not need to use a condom with their "main" partner also admitted that they were aware of the risk posed by unsafe sex with a purportedly monogamous partner, often from personal experience. The difficulty associated with introducing condoms into a relationship with a main partner was clearly demonstrated by the story of one woman, who, after repeatedly having trusted, had unsafe sex with and became infected with several STDs by various partners, had this to say about her current main partner:

> Now I know. Yeah, everybody wants to believe [that their partner is faithful], but you know what? I learned. Well, I know now that my husband and I are the only two, 'cause we're together 24-7. (Ann, former sex worker)

Finally, some women suggested that women who did not use condoms either did not care about themselves or were just not thinking:

> It's a spur of the moment thing, and they don't care if it's . . . they're right heated up at the moment, they're in the car with that person, and they're getting all hot and horny and bothered, and they just want to pull over and have sex. They don't care if they get a disease. They're not thinking about the consequences. (Ann, former sex worker)

Suggested Interventions

When given the opportunity to suggest interventions that would be effective at increasing condom use, the participants were eager to give their advice. Their suggestions are categorized below into the type of intervention, the target audience, the agents of intervention, and the medium and location of the intervention.

Type of Intervention

The proposed interventions fell into four somewhat overlapping categories: availability, awareness, education, and testing. By far, the most frequently endorsed intervention was to have condoms available everywhere possible:

> I mean, it would be nice if the whole world just had condoms laying around so . . . you know, make it accessible, and then, yeah. They'll at least have a condom in their pocket and be able to make the choice then. (Helen, former IDU and sex worker)

There was consensus in each focus group that condoms should be more widely available, whether in bowls, baskets, or more complicated devices similar to mailboxes. Such unstaffed methods of distribution were deemed ideal, as they were discreet and would limit potential embarrassment. Some women proposed that condoms distributed in person would also be an effective intervention. However the condoms are dispersed, many women indicated that they need to be free, of high quality, and available in a variety of colors, brands, and types.

The expressed need for wide availability of condoms was often paired with a need for increased awareness of the problems of AIDS and unplanned pregnancy. The women expressed a sense that these issues were not getting enough high-profile coverage via the various media and that people would use condoms more often if they were confronted daily with information and images of the consequences of failure to use condoms. Relatively simple, eye-catching slogans (e.g., "USE CONDOMS!") were suggested as an appropriate means to communicate this information. In addition to using billboards, signs, and posters, many women suggested putting "hip" or humorous public-service announcement on television and radio.

Above and beyond simple awareness of the potential consequences of unprotected sex, many women recommended education about how to protect oneself. (Much of the discussion of education centered on the need to provide sex education to children and is discussed later, in the "Target Audience" section.) Suggested condom promotion strategies were often a loosely defined combination of awareness and education. One creative suggestion was borrowed from restaurant marketers:

> I mean, if they can go around and hand out little restaurant menus twice a month, why can't you go around and stick a flier in the door about teenage sex, or using safe sex and condoms? We're trying to cut down on the world coming down with AIDS and HIV. Why can't we put fliers in the doors? People be like, "Oh, I didn't know that's how many people get AIDS every year," and "I didn't know how many people get HIV," and "Condoms does this," and "Condoms does that." (Carolyn, former sex worker)

Although mentioned by only a few women, support groups were identified as a means to educate people about condom use, particularly small groups of people with similar experiences, such as prostitutes. A few women expressed reservations about the effectiveness of the "active" forms of intervention compared to more discreet, passive methods. Incentives, ranging from cash to vouchers for used clothing, were often suggested to encourage participation in educational programs that would otherwise be poorly attended:

> And maybe offer 'em bus fare. I mean, give 'em an incentive. You know, it's $2.50 to get a day pass on the bus now. You know, don't give 'em cash, but give 'em some bus tokens or something. Give 'em some incentive, but then let them have their pride too, you know? (Helen, former IDU and sex worker)

Finally, there were a few suggestions that HIV testing be made more available. As with other strategies, the women emphasized the need for the testing to be discreet and free. Although receiving HIV test results cannot be considered a form of prevention, it was seen as an important element of AIDS education, and although the women who expressed a desire for testing wanted it to be confidential, some felt a need to identify those individuals who were HIV positive and knowingly spreading the disease by having unsafe sex. Several women were familiar with men and women who were contributing to the spread of AIDS in this manner.

Target Audience

The interventions outlined by the women tended to target teenagers, prostitutes, or the general population. Almost invariably, following the explanation of the purpose of each focus group, a participant insisted that prevention had to start with the children. Typically, participants described prevention in terms of openness of communication about sex or sex education. The women were concerned about both teenage pregnancy and AIDS and other STDs. Many had personal stories involving young family members or close friends whose lives were changed forever by teenage pregnancy or HIV infection. Beyond early and consistent sex education, many women mentioned targeting children for other prevention efforts, including condom distribution. Children and teens were perceived as having even more obstacles in the way of their obtaining condoms than did adults.

> These kids don't want to admit to anybody that they're out there having sex. So they aren't gonna necessarily come up and say "Hey, can I have some condoms?" (Ann, former sex worker)

After children, the next most commonly mentioned target audience for a condom intervention program was prostitutes. All the women had either been "working girls" or were intimately familiar with the lifestyle. Based on this experience, most felt that prostitutes would take full advantage of any condom program, particularly those increasing the availability of condoms:

> Because I like, I know the places where the working girls hang out, hang out on the streets. And they're either going into like a liquor store to grab 'em a couple little shotties and drink, or, you know, they're going' somewhere. But they're always gonna run in a bathroom to freshen up or, or whatever, whatever, you know. But if

> they were to go in there first and see some type of condoms, "Let me get a couple," you know? (Carolyn, former sex worker)

Other than the above-mentioned two groups (prostitutes and children/teens), no consistent target audience emerged from the discussions of desired interventions. When directly asked whether the interventions needed to be tailored to particular subgroups, most women agreed that their proposed interventions would be just as successful with one group as with another. Furthermore, they tended to agree that all segments of society would benefit from these interventions, regardless of age, drug use, gender, and occupation.

Agents of Intervention

The proposed interventions had a number of sources, including family members, schools, and the broader community, as well as social service agencies. However, for the majority of the interventions suggested, the implicit assumption was that staff from various social service agencies would be conducting the condom promotion activities. When asked about the specific characteristics that, for example, an outreach worker would need to have to be successful, most women stated that it wouldn't make a difference who did it:

> Any kind of nice health care worker—you could do it. Just some people that are concerned citizens, you guys could do it . . . I, I'll be out there wit' chya [laughing]. Anybody. (Pearl, former IDU and sex worker)

Other women believed an intervention would be more successful if those doing the intervening had experiences similar to those of their target audience. The thought was that someone would be more willing to take advice from a person who had lived the same lifestyle as they had. For example, one woman who had talked to homeless shelter residents about condom use felt they listened to her because she had lived there previously. However, most women did not think that outreach workers would need to be physically similar to their target, for example with respect to race or ethnicity, gender, or age, to be effective.

Location of Intervention

In general, the locations for the interventions were selected because that was where the particular target audience would most likely be found; "All you gotta do is follow the traffic" (Sandra, former IDU and sex worker). The underlying assumption was that to increase efficacy, you bring the intervention to the audience, not the other way around. Most of the suggested locations were offered as prime spots to conduct any or all of the condom promotion strategies outlined above. The following were considered particularly ideal places for dispensing condoms and providing educational pamphlets: the transit center, public restrooms, bars, homeless shelters, malls, doctors' offices and clinics, and regular and adult movie theaters. The transit center was by far the most frequently-cited "hot spot" in which to provide these materials. Bars, clubs, and adult movie theaters were identified as good places for an intervention, because many women associated both places with the initiation of sexual activity:

> And definitely, if you were in a strip joint and the men went into the bathrooms, they'd be like, "Man let me grab a couple of these." (Carolyn, former sex worker)

> The bars downtown. Because there's a lot of working girls what go in there. And pick up men. (Jackie, former sex worker)

With respect to placement of posters and signs, the women agreed that buses were the best means for spreading awareness. They suggested messages about AIDS, teenage pregnancy, and condoms be placed both inside and outside the buses to reach the greatest number of eyes. Similarly, the radio waves were considered a great place to broadcast messages about safe sex to a large number of listeners.

Participants considered the transit center, health fairs, and the homeless shelter to be good locations for active efforts to educate the public. In particular, the homeless shelter was considered ideal, as it provided not only a captive audience but one in dire need of a number of social services, including HIV prevention programs.

Current/Past Interventions

We asked focus group participants to identify unsuccessful condom promotion programs. Surprisingly, most women indicated they were unaware of any current condom promotion activities. Many of the women who had participated in local substance abuse treatment programs reported that the programs were lacking in their coverage of such topics as safe sex, HIV, and STDs. Those women who were able to identify current or recent condom promotion strategies never described them as unsuccessful. Indeed, as articulated by this woman, there was a sense that no condom promotion strategy would be a waste of money:

> I don't think any of it's a joke or a waste of money actually. As long as the point's getting across . . . any place that people are seeing it, I don't feel is a waste of time. 'Cause somebody's gonna read it. (Faith, former sex worker)

Several women expressed concern that there seemed to be even fewer condom promotion strategies today compared to 5 or 10 years ago. A few of the participants linked this perceived reduction in the number of AIDS awareness, condom distribution, and sex education programs with increasing pressure from conservative groups.

DISCUSSION

We conducted this set of focus groups with a sample of women at high behavioral risk for HIV to gain insight into their perceived needs regarding condom use interventions. The women are aware of many reasons they and others would choose not to use a condom and believe that many of these factors might be addressed successfully with their suggested interventions: condom availability; public awareness and education about HIV, STDs, and unplanned pregnancy; and HIV testing. The participants were unable to identify current or prior interventions that they felt were ineffective. On the contrary, many were concerned by the relative lack of

extant condom promotion strategies and suggested that any increase in these programs would be of benefit.

By far the most frequently endorsed condom promotion strategy was the widespread distribution of free, high-quality condoms. There is evidence that condom availability and condom use are correlated (Brook et al., 1998). Despite the apparent success of condom availability programs abroad, relatively few such programs have been implemented or evaluated in the United States (see Cohen, 1999, for a review). Cohen, Farley, et al. (1999) documented significant increases in self-reported condom use following a 2-year statewide condom social marketing intervention, which included distribution of more than 33 million condoms. In fact, high-risk minority women evidenced some of the largest increases in condom use. In addition, there is some support for focus group participants' suggestion that condom distribution would be especially effective if the condoms were free (Cohen, Scribner, Bedimo, & Farley, 1999) and if a variety of brands and types were made available (J. Williams, Christensen, Cagle, & Homan, 2001). Given the relative cost of providing condoms versus health care for HIV-positive persons (Pinkerton, Johnson-Masotti, Holtgrave, & Farnham, 2001), the extent to which a large-scale condom availability program would be effective among current and former drug-using women needs to be tested.

The suggestion to increase public awareness of AIDS and condom use corresponds with many behavior change models that target social norms, such as the Theory of Reasoned Action (Fishbein & Ajzen, 1975) and the Theory of Planned Behavior (Ajzen & Madden, 1986). In a large sample of high-risk individuals, including IDUs and sex workers, Kasprzyk, Montano, and Fishbein (1998) found social norms to be significantly related to subsequent condom use for both main and casual partners. Noting the relative failure of sexual behavior change interventions, researchers have increasingly begun to highlight the need to create and maintain safer sex norms (Gibson, McCusker, & Chesney, 1998; Rhodes et al., 1996). There have already been some documented successes of this social norms/network approach, most notably among populations of gay men (Kegeles, Hays, & Coates, 1996; Kelly et al., 1997) but also among IDUs (Latkin, Mandell, Vlahov, Oziemkowska, & Celentano, 1996) and low-income women (Sikkema et al., 2000). This encouraging preliminary evidence, coupled with focus group participants' requests for similar programs, indicates a need to evaluate the effectiveness of this approach for reducing sexual-risk behavior among drug-using women.

The majority of HIV-preventive interventions are based on a cognitive-behavioral approach, that is, they provide information (e.g., risk and preventive behaviors associated with HIV) and build relevant skills (e.g., how to use a condom). In contrast, this prevention strategy was much less widely endorsed by participants compared to condom availability or awareness programs. Recent reviews of HIV prevention interventions have concluded that the cognitive-behavioral approach has been somewhat effective in changing condom use behavior (National Institutes of Health [NIH], 1997; Rotheram-Borus, Cantwell, & Newman, 2000), particularly when a skills component is included (Ehrhardt & Exner, 2000). However, it is also clear that education alone is not sufficient. One of the criticisms of the cognitive-behavioral approach when applied to condom promotion among women is that it focuses on individual beliefs and skills to the neglect of characteristics of the sexual partner, the relationship with that partner, and the socioeconomic context in which

the woman lives (Amaro & Raj, 2000). Such programs will likely be only minimally effective in cases where these other factors play a significant role in a woman's ability to get her partner to use a condom (e.g., for women in domestic abuse situations).

The strategies suggested by the focus group participants appear to be sound, reasonable recommendations and deserve the notice of the appropriate local program developers and evaluators. However, it is also likely that given access to free condoms, exposure to awareness campaigns, and the opportunity to receive AIDS education and testing, many individuals will still engage in unprotected sex. It might be that the focus group participants identified the subset of programs that would be effective only for those already at a high level of readiness for change (Prochaska, Redding, Harlow, Rossi, & Velicer, 1994); for the majority of individuals not already contemplating using condoms in the future, these interventions might not be effective. In many cases, most notably with a main partner, men and women alike choose to forgo condoms, perhaps based on the belief that both they and their partner can be trusted to be monogamous (Kline, Kline, & Oken, 1992). Given the facts about levels of marital infidelity and the length of time HIV can lie dormant, these decisions might be evidence of wishful thinking or denial winning out over rational choices. This struggle between knowing that risk is involved in having unprotected sex with their main partner and wanting to believe in their partner's fidelity was evident in the comments of the focus group participants. Clearly, one of the toughest challenges ahead will be developing condom promotion interventions that are effective within longer term relationships (Gielen et al., 2001).

Furthermore, some women might be unable to engage in safer sex, not because of a lack of condoms, information, or awareness but because their partners will not use a condom. Use of the male condom requires the active participation of the male partner, one of the criticisms of reliance on male condom–centered HIV prevention (Gollub, 1995). Male partners who do not wish to use a condom might resort to violence in an angry response to a request to do so or as a means of obtaining the unprotected sex they desire. The evidence indicates this association between partner abuse and unprotected sex is not unusual (Gilbert, El-Bassel, Schilling, Wada, & Bennet, 2000; Wingood & DiClemente, 1997). Even without the threat of abuse, the condom use of many women is influenced heavily by their male sexual partners. Recent studies found that for a high-risk woman in particular, the norms of her partner (i.e., whether he thought they should use a condom) appear to be significant predictors of condom use and intentions, regardless of whether he is a main or casual partner (Johnson, von Haeften, Fishbein, Kasprzyk, & Montano, 2001; Kenski, Appleyard, von Haeften, Kaspryzk, & Fishbein, 2001). This suggests that interventions aimed at changing sexual-risk behavior among heterosexual couples might have only marginal effectiveness if they do not involve both partners (El-Bassel et al., 2001).

The limitations of this study need to be addressed. The study was conducted using a small convenience sample of former drug-using women from a particular geographic area, all of which might limit the generalizability of the findings. Studies with small *n*'s, although typically inappropriate for hypothesis testing, might be very well suited to research objectives like that of the current study, which was to gain a better understanding of one high-risk group's perceived needs for condom use interventions. As saturation was achieved with the small number of groups run, it is unclear what would have been gained by running additional focus groups. The problem of generalizability to women known to be currently using drugs might be

attenuated by the fact that all the participants were women who had at one time been drug users; thus, they presumably still retained awareness of the "drug user's perspective" on issues such as condoms use. In addition, participants repeatedly rejected the idea that any of the condom promotion interventions would need to be designed differently for drug users than for non–drug users. Thus, the applicability of their suggestions might actually be broader than to current and former drug-using women.

The value of the findings presented in this article is as a preliminary step in the progression toward implementing effective condom use interventions. Just as it is important to involve community members in this early stage of needs assessment, so, too, is it critical to continue to include community members in the subsequent stages of intervention development, recruitment, implementation, and evaluation (Isreal et al., 1998; Sormanti, Pereira, El-Bassel, Witte, & Gilbert, 2001). Given the challenges inherent in developing and maintaining effective preventive interventions, it seems the chances of success can only be increased by combining the strengths of multiple perspectives (e.g., academic researchers and community members) and multiple methodologies (e.g., qualitative and quantitative).

As a final note, in this study, we focused solely on understanding drug-using women's proposals for interventions to increase use of male condoms. For many reasons, some of which we have discussed, this might not be the most practical or effective risk reduction strategy for everyone. It is not our intent to suggest that the search for an effective male condom intervention should continue at the cost of research into alternative methods. Women-centered methods in particular, because they remove the necessary involvement of the male partner, hold much promise (Gollub, 1995), but until the female condom has achieved higher levels of acceptability (Cecil, Perry, Seal, & Pinkerton, 1998) and the research on microbicides has developed further, use of the male condom will likely remain the cornerstone of sexual risk reduction interventions. The ultimate objective is not to have everyone use male condoms for all sexual encounters but for everyone—man, woman, drug user or not—to have multiple safe, effective, and realistic options for sexual risk reduction at their disposal.

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