The sexual health experiences and motivators of Black heterosexual men in London: A qualitative study including higher-risk behaviours.

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Abstract

Background: Black ethnic groups in the UK disproportionately experience poor sexual health outcomes. This appears to be more pronounced amongst Black men and has been attributed to a complex interplay of individual, behavioural, cultural and structural factors. Drivers of these disparities are poorly understood and remain under-researched. Previous research has identified a gap around understanding of Black men's behavioural experiences and factors motivating protective behaviours in a UK context. This study aimed to address this gap through exploring the sexual health experiences and motivators of Black heterosexual men in London.

Methods: A qualitative design with in-depth semi-structured interviews was adopted to obtain a rich account of experiences. The sample consisted of 10 participants aged between 18-58 years. Participants were recruited through three Barbershops in London. Reflexive thematic analysis was used to analyse transcribed interview data.

Findings: Five themes were constructed: 1) Accountability and responsibility: a real man; 2) The Black man's battle; 3) Sexual socialisation; 4) Liberal London; and 5) Sexual behaviours, relationships, and health. Perceptions of masculinity shifted with age. During adolescence, masculinity was signalled through multiple sexual partners. As participants aged and matured, perceptions of masculinity developed to largely revolve around meeting the needs of family and loved ones. Race and gender combined to significantly influence participants' experience of sexual socialisation. Exposure to explicit media content from a young age promoted multiple sexual partners. Racist sexual stereotypes resulted in participants experiencing fetishization of their Black male bodies and created pressure to meet expectations regarding sexual activity. Condom use motivators were complex and multifaceted. Trust, perceived STI threat and perceived potential parenting were all described as influential factors in condom use decision making. Sexual health service use was influenced by previous experience of institutional racism and the fear of stereotyped Black male sexuality which in turn underpinned a lack of trust in services. However, actual experiences with sexual health services were largely positive and counteracted the mistrust created by racism.

Implications: The study findings highlight the need for sexual health services to better tailor their work to Black heterosexual men and diversify their offer. Services should build relationships with Black community organisations to facilitate service provision outside the clinical setting.

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Yo look, no we ain't hooligans

Just young and talented Nubians

With potential and promise

Innovative young masterminds like Sean Wallace

Ashley “Bashy” Thomas – Black Boys

1.0 Introduction

Rates of Sexually Transmitted Infections (STIs) continue to present public health authorities in the United Kingdom (UK) with significant challenges (Browne et al., 2021). Worrying disparities, including poor sexual health outcomes among marginalised groups in society remain a prominent issue but are masked by progress in general population sexual health outcomes (Health and Social Care Committee, 2019; Mohammed et al., 2018).

People of Black ethnicity have experienced a disproportionately high burden of STIs in the UK since the late-1980s (Lacey et al., 1997).

The disproportionate burden of STIs appears to be more pronounced among Black men and varies between Black ethnic groups, with people of Black Caribbean ethnicity experiencing longstanding higher rates of bacterial STIs (Public Health England, 2021b). One study among Genitourinary Medicine (GUM) clinics in the UK revealed that Black Caribbean men were more likely to be diagnosed with at least one acute STI on the day of clinic attendance and almost twice as likely (45.4%) to be diagnosed with a bacterial STI than White men (24.4%) (Gerressu et al., 2012). STI data from 2018 shows the rate of gonorrhoea was seven times higher among Black Caribbean men than White men in 2018 (Public Health England, 2019a).

People of Black African ethnicity remain disproportionately affected by HIV (Fakoya et al., 2019). In 2017, among heterosexuals, people of Black African ethnicity accounted for 57% (24,548/42,668) of those receiving HIV care compared with 26% (11,058) of White ethnicity (Public Health England, 2018).

At both individual and population levels, poor sexual health can present serious reproductive, physical and mental health issues including genital and other cancers, infertility, increased mortality and morbidity, and lowered wider wellbeing (Aral, 2001; Public Health England, 2015).

1.1 Drivers of inequalities

Surveillance data has enabled public health authorities to identify populations most affected by STIs, however, data alone does not facilitate an understanding about why some subgroups have higher STI rates than others (National Academies of Sciences, Engineering, and Medicine, 2021). Whilst ethnic and racial disparities in STI rates are well documented,

the drivers of these are poorly understood (Jewkes & Dunkle, 2017) and have been attributed to a complex interplay of individual and structural level cultural, socioeconomic and behavioural factors (Public Health England, 2019a). Understanding the structural and social factors linked with these disparities is vital for the design and development of relevant and appropriate preventative interventions (National Academies of Sciences, Engineering, and Medicine, 2021).

1.1.1 Individual-level behaviours

At individual-level, there may be a gendered contrast to behavioural drivers of high STI rates among Black ethnic groups as higher-risk sexual behaviours appear to be more prominent among Black men and are said to include higher numbers of recent sexual partners and higher rates of concurrent sexual partnerships, condomless sex and assortative sexual mixing patterns (Public Health England, 2019a; Wayal et al., 2017; Wayal, Aicken, et al., 2018). Conversely, findings from the Attitudes to and Understanding of Risk of Acquisition of HIV (AURAH) study revealed that Black women reported less frequent sexual risk behaviours than their White counterparts (Coyle et al., 2018). Furthermore, Wayal et al (2018a) conducted a systematic review of 15 UK-based studies to examine whether ethnic differences in factors associated with an increased risk of STIs could explain the ethnic variations observed in STIs at a population level. The findings revealed that whilst Black Caribbean men were more likely than White British men to report onset of sexual activity under 16 years, sexual concurrency and multiple partners, there were no differences observed amongst women.

Condom use remains a vital tool in the prevention of STI transmission as correct and consistent use during sex can significantly reduce likelihood of STI transmission (Public Health England, 2018). Despite this, many barriers to condom use have been reported, including resistant attitudes, diminished sexual pleasure, problems regarding their fit-and-feel and problems acquiring and maintaining an erection whilst using condoms (Stone et al., 2018).

Higher rates of condomless sex have been reported among Black men with one study revealing condomless sex with more than one partner in the past year was more commonly reported by Black Caribbean (11.6%) and Black African men (7.7%) than their White British counterparts (7.4%) (Elam et al., 1999; Wayal et al., 2017).

Whilst individual-level behavioural interventions may be better served targeting Black men, disparities in sexual health outcomes among Black ethnic groups persist even when controlling for individual behaviour as STI acquisition occurs through an association with a partner, meaning the probability of acquiring an STI is equally dependant on the behaviour of a partner as one's own behaviour (Coyle et al., 2018; Hamilton & Morris, 2015). Although individual-level determinants largely drive STI risk and transmission, at population-level, transmission of infectious diseases are further driven by an interplay of infection presence and a range of social and structural environmental factors (Dean & Fenton, 2010). This indicates a need to look beyond individual-level factors and explore patterns of exposure alongside environmental factors which facilitate STI transmission (Ghani et al., 1997), like the sexual networks Black men are members of.

1.1.2 Sexual networks

Sexual networks are groups of people connected to one another sexually (Potterat et al., 2000). Sexual networks influence an individual's STI risk as STI prevalence within a sexual network and the individual's position within the network may be just as impactful on their risk as much as their own sexual behaviours (Adimora & Schoenbach, 2005; Jolly & Wylie, 2002; Rothenberg, 2009). Core groups of people engaging in high-risk sexual behaviours who are subsequently introduced to sexual networks are essential for STI transmission as the centrality of these individuals, percentage of monogamous relationships and number of links each has to others are said to determine the rate at which an STI can spread through a network (Jolly et al., 2001; Potterat et al., 2000).

A UK-based study exploring associations between ethnicity and sexual risk in heterosexual people attending sexual health clinics reported a disparity between STI history and self-reported sexual risk behaviour, leading the authors to conclude that STI risk is determined by interactions within sexual networks rather than at individual-level (Coyle et al., 2018). This was supported by the findings from a longitudinal study (Bardsley et al., 2022) exploring the disproportionate burden of STIs in heterosexual-identifying people of Black Caribbean heritage. The study found no unique predictors of incident STI for Black Caribbean participants, leading the authors to conclude that the dynamics of sexual networks may be of greater influence on STI acquisition than individual-level factors (Bardsley et al., 2022).

Data from the National Surveys of Sexual Attitudes and Lifestyles (Natsal) 3 revealed that in the UK, heterosexual people tend to engage in assortative sexual mixing which sees them sexually engaged with people of the same or similar ethnic groups as them (Doherty et al., 2005; Geary et al., 2019). This could have implications on the disproportionate burden of STIs observed among Black ethnic groups.

Greater understanding on associations between dynamics of sexual networks and sexual mixing patterns, and STI risk among Black men in the UK is required. Where studies have been conducted, these have often focussed on men who have sex with men (MSM) and heterosexual men of Black Caribbean ethnicity (Aicken et al., 2020; Doerner et al., 2012). However, among heterosexual men and women born abroad but diagnosed with HIV in England, of which people of Black African ethnicity are overrepresented, 49% were estimated to have acquired HIV after migrating to the UK (UK Health Security Agency, 2021).

A major component of sexual networks that enhances the transmission of STIs is concurrent sexual partnerships as the prevalence of concurrency impacts both the speed of transmission and the number of individuals who acquire an STI (Adimora & Schoenbach, 2005; Kretzschmar & Morris, 1996).

1.1.3 Concurrent sexual partnerships

Concurrent sexual partnerships, where individuals have more than one sexual partner in the same time period (Public Health England, 2018) significantly increases the opportunity of STI transmission (Morris & Kretzschmar, 1997). Firstly, as one sexual relationship does not end before another begins, the time between acquiring an infection and passing it on is significantly reduced. Secondly, when sexual relationships overlap in time, later partners can pose a risk to earlier sexual partners (Moody, 2002).

The impact of sexual concurrency on the spread of STIs cannot be underestimated as research has demonstrated that even modest differences in concurrency can dramatically affect connectivity in sexual networks (Morris & Kretzschmar, 2000). The scale of connectivity of sexual networks is said to increase the probability of STI transmission across networks throughout the population (Adimora & Schoenbach, 2005).

In one study exploring STI risk exposure among racially minoritised young people in Northwest London, young Black Caribbean women commonly reported being in passive,

“closed from their end”, “main plus” concurrent sexual partnerships which resulted in their STI risk being largely determined by their partner’s concurrent partnerships (Gerressu et al., 2009). Furthermore, research in the USA has revealed that variations in the prevalence and duration of concurrent sexual partnerships and sexual mixing patterns by race exacerbated the racial disparities observed in the HIV epidemic potential (Morris et al., 2009, 2010).

In the UK, the prevalence of concurrent sexual partnerships is higher among Black men with data from Natsal-2 revealing that amongst respondents, 41.6% of Black Caribbean and 43.8% of Black African men reported having at least one new heterosexual partnership in the past year compared with 29.6% of their White counterparts (Fenton et al., 2005). The authors estimated that just over a quarter of Black Caribbean and a third of Black African men had engaged in concurrent sexual partnerships in the preceding year, significantly higher than the proportion of White men engaging in concurrent sexual partnerships. Similar trends were observed in data collected from Natsal-3, where greater proportions of concurrent sexual partnerships were reported by Black Caribbean and Black African men (26.5% and 38.9% respectively) compared to White British men (14.8%) (Wayal et al., 2017).

Attitudes towards sexual concurrency among Black men in the UK are not well understood and have shown a tendency to focus on Black Caribbean men despite Black African men reporting a greater proportion of concurrent sexual partnerships (Wayal et al., 2017). One study highlighted the role of social factors like popular music, social media and celebrity culture on the normalisation and celebration of sexual concurrency, particularly among Black Caribbean men. However, future research is required to explore the prevalence of different types and characteristics of concurrency due to the varying levels of STI risk they present (Wayal et al., 2020).

1.1.4 Socioeconomic deprivation

Socioeconomic deprivation (SED) is well documented as a major determinant of poor health and recognised as a contributor to the health disparities observed among ethnic minorities (Marmot, 2005; Shavers, 2007).

Deprivation is a multidimensional concept that captures disadvantages individuals or social groups experience regarding access and control over economic, material or social resources

and opportunities (Denny et al., 2016; Lamnisos et al., 2019). Those living in deprivation often lack several resources relating to income, employment, skills, adequate shelter and poor access to healthcare (Butler et al., 2013; Rowley et al., 2021).

The link between SED and poorer health outcomes is clear. The most socioeconomically advantaged in society are observed to have the best health outcomes whilst those in the most deprived communities have the poorest outcomes (Benzeval et al., 2014). This has been demonstrated consistently across several health areas including cardiovascular disease, diabetes, low birthweight and the recent COVID-19 pandemic (Dearden et al., 2020; Kavanagh et al., 2010; Warner et al., 2021). The link between SED and risk of STI acquisition is also well documented (Crichton et al., 2015; Furegato et al., 2016; Hughes et al., 2013; Le Polain De Waroux et al., 2014; Sonnenberg et al., 2013).

The experience of SED among Black ethnic groups in England is multifaceted. Black ethnic groups are more likely to live in the most deprived neighborhoods in England (Ministry of Housing, Communities and Local Government, 2020); are more likely to live on a persistent low income, in persistent poverty and overcrowding (Department for Work and Pensions, 2021); are disproportionately represented in the victims of violent crime and murder (Kumar et al., 2020); and are overrepresented at all stages of the criminal justice system (Blake, 2018; L. Robertson & Wainwright, 2020). The Race Disparity Audit revealed that people of Black ethnicity in England were also more likely to be in receipt of income-related benefits and tax credits, be unemployed, rent social housing and live in lower quality housing (Cabinet Office, 2017).

The structural disadvantages experienced by ethnic minority groups, alongside their structural concentration in particular geographical locations must be acknowledged (Nazroo, 1998). There is now widespread acknowledgment that the social conditions that people are born, nurtured, live, work and age significantly influence their health across the lifespan (Rowley et al., 2021).

Mechanisms have been proposed to explain the harmful health behaviours observed more prevalently among socially disadvantaged groups. One such explanation is that socially disadvantaged groups, including Black men, engage in unhealthy behaviours as a coping strategy for the difficult situations they live through. Negative consequences of being

socially and/or economically unequal can result in the uptake of unhealthy behaviours, including risky sexual behaviours as a means of coping with inequality and this may stem from the impact of stress and hopelessness on self-esteem (Lohan, 2007). It is argued that difficulties of coping with SED results in reduced concern about the health-damaging effects of behaviours that provide pleasure or stress relief (Benzeval et al., 2014). Researchers have also suggested that socioeconomically deprived persons engage in high-risk behaviours because of lower self-esteem, perceived limitations of life choices and limited control over what happens to their health (Hughes & Gorton, 2015).

Several studies have highlighted the association between SED and STIs, however mechanisms are limited (Furegato et al., 2016; Mitchell et al., 2014; Mohammed et al., 2018; Savage et al., 2011). Establishing causal pathways in relation to complex problems can be challenging as these pathways are often diverse and interlinked (Wight et al., 2016).

In the UK, there is a paucity of studies exploring the impact of SED on the sexual health, attitudes and behaviours of adult heterosexual men (McDaid et al., 2012). However, studies in the USA have revealed that heterosexual individuals of lower socioeconomic status, are more likely to be confined to dense sexual networks with high rates of active STIs (Denning et al., 2011). This could explain the persistent incidence of gonorrhoea in large urban cities like London with high levels of SED, more dense sexual networks, high rates of partner change and poor access to treatment (Hughes & Lowndes, 2014). Regarding utilisation of testing facilities, a UK study exploring factors associated with the return of home sampling STI testing kits requested online revealed that heterosexual men and those from neighbourhoods with higher SED were less likely to return their sampling kits (Manavi & Hodson, 2017).

There are no known biological factors that explain racial and ethnic disparities observed in STI rates, however, race and ethnicity are associated with factors known to determine health including poverty and deprivation (Fenton et al., 1997). Whilst SED alone and individual-level behavioural risk factors do not fully explain the racial and ethnic disparities observed in STI rates, contextual factors, such as poverty, SED and discrimination shape the social context and determinants that enable STI transmission beyond individual-level behaviour (Brawner, 2014).

Associations between SED and health inequalities are further complicated by intersections between race and gender. With SED unable to entirely explain STI disparities observed among marginalised groups, including Black ethnic groups, wider sociocultural and structural constructs must be explored (Evans-Campbell et al., 2007).

Some scholars argue that the health disparities observed among Black ethnic groups are largely determined by social and economic inequalities, and exposure to racial harassment and discrimination (Harris et al., 2006; Karlsen & Nazroo, 2002; Nazroo, 2003). This could be strongly linked to the experience of growing up with a Black identity in a context of structural racism rather than being of a racial or cultural background. This has direct and indirect influences on sexual behaviour and sexual networks through various mechanisms and likely contribute significantly to the persistence of observed racial and ethnic disparities in STI rates (Adimora & Schoenbach, 2005).

1.1.5 Racism

Racism has long been acknowledged as a social determinant of health and driver of observed racial and ethnic disparities in health outcomes (Williams & Mohammed, 2009). A multi-faceted concept occurring at both structural and individual levels, racism underpins a complex and organised system which sees ethnic groups classified into social hierarchies and ideologically assigned differential values which promote disparities in access to power, resources and opportunities (Krieger, 2020; Williams & Mohammed, 2013).

Racism is said to occur in three distinct ways. Firstly, institutional and structural racism refer to processes that encourage racial disadvantage and differential access of economic, physical and social resources. These are legitimised through the routine policies, procedures and norms of large social institutions (Jones, 2000; Williams et al., 2019). Secondly, the social ideologies that initiate and maintain harmful racial stereotypes towards stigmatised groups promote both implicit and explicit biases amongst the wider society (Boutrin & Williams, 2021; Jones & Neblett, 2017). Finally, interpersonal racism reflects the discriminatory treatment observed during personal interactions and include acts of verbal and physical abuse, and the ignoring or avoiding of individuals or groups due to their ethnic background (Kapadia et al., 2022).

Racism is argued to affect health outcomes through several mechanisms at various levels. At structural level, racism may impede fair access to societal resources that determine health, including education, employment and housing and access to healthcare (Ben et al., 2017; Williams & Mohammed, 2013). Experiencing racism is also said to decrease an individual's energy and self-control resources which can encourage their engagement in maladaptive health behaviours whilst discouraging them from engaging with preventative health behaviours (Pascoe & Smart Richman, 2009). Finally, experiencing racism, particularly from healthcare providers has been suggested to decrease an individual's trust and satisfaction with the health care system and increase the likelihood of the individual delaying or avoiding seeking care altogether (Lee et al., 2009; Rivenbark & Ichou, 2020).

Despite the overwhelming evidence suggesting that racism is a fundamental cause of the racial disparities observed in health outcomes, and access to and experience of healthcare services, racism is often omitted from research and policy debates (Kapadia et al., 2022; Williams et al., 2003). Moreover, responses to ethnic health inequalities have been unclear, disjointed and costly (Naqvi et al., 2022). Denial that racism exists on a systemic level is likely to sustain and reproduce the racism observed in healthcare and present challenges in implementing change (Gill & Kalra, 2020).

In sexual health care, Black ethnic groups have long been identified as a sub-group with greater sexual health needs, alongside young people (YP) and MSM (Reid, et al., 2018), yet a special interest group (SIG) for racially minoritised populations has only recently formed at the British Association of Sexual Health and HIV whilst SIGs have existed for YP and MSM for decades (Hunt & Nwaosu, 2022). Furthermore, professional guidance (Public Health England, 2021a) for promoting the sexual health of Black Caribbean people has also only recently been published despite the longstanding burden of STIs observed within this population.

For Black men, the general mistrust in larger society because of their experiences of racism is argued to discourage engagement with sexual health care (Conserve et al., 2017). Furthermore, for Black men, race and racism are inseparably linked to their sexuality (Bowleg et al., 2017). In the USA, the early rationale for the Tuskegee Syphilis study, during which Black men were deceivably denied treatment for syphilis by government researchers whilst they researched the effects of untreated syphilis, was underpinned by racist

stereotypes about the high prevalence of syphilis in poor Black communities and the reluctance of Black men to seek treatment in the absence of severe symptoms (Brandt, 1978).

Research among Black American males has demonstrated a link between the experience of racism and engaging in risky sexual behaviours (Bowleg et al., 2013; Grollman, 2017; Reed et al., 2013; Roberts et al., 2012) although these have mainly focused on sexual behaviours in the context of HIV risk and mechanisms remain unclear. One cross-sectional study of 526 Black heterosexual men in Philadelphia, USA empirically demonstrated that the experience of frequent racism was associated with post-traumatic stress symptoms which subsequently mediated increased sexual risk behaviours (Bowleg et al., 2014). More recently, a longitudinal study of 505 young Black heterosexual men in Georgia, USA revealed that experiences of racism predicted emotional distress, substance use and reduced self-regulation which mediated the association between racism and risky sexual behaviours including concurrent sexual partnerships and inconsistent condom use (Hicks & Kogan, 2019). The design of these studies do not allow for the establishment of casual explanations, suggesting a need for research to better understand the link between these factors, particularly in a UK context.

It has also been suggested racism can harm the sexual health of Black men through the marginalisation associated with being a Black man, experiencing SED, residential segregation, and inadequate healthcare (Krieger, 1999). Men who experience marginalisation are said to encounter challenges in fulfilling certain masculine norms such as providing for one's family due to structural and social inequalities that deny them equitable access to employment institutions and power that is available to certain men. Without access to these power structures, these men are seen to have significantly reduced options for fulfilling societal expectations of men, thus their most practical option to demonstrate masculinity and manhood is by engaging in unhealthy behaviours that increase their risk of disease, injury or bodily harm (Fleming et al., 2016).

1.1.6 Masculinity

Socially constructed gender norms, particularly masculinity norms, largely promote sexual behaviours which increase STI risk (Higgins et al., 2010). With male sexual behaviour playing a fundamental role in the construction of masculine identities, men's STI risk – and that of

their sexual partners – can be viewed as a product of masculinity. Viewing sexual behaviours from a gender identity approach aids understanding regarding why they are difficult to change alongside how interventions can approach change (Jewkes & Morrell, 2010).

From an early age, men are socialised to endorse masculine norms whilst deviations from male gender scripts attract condemnation (Addis & Cohane, 2005; Pleck, 1995). Furthermore, individuals are said to construct their gender through performance, a combination of repeated actions, behaviours and interactions (Butler, 1993). Gender is understood as something that individuals do, rather than what they are, meaning masculinity relies on both public behaviours and how the respective social environment judges them. Men are alerted to their failings in upholding societal expectations of them through both formal and informal methods including jokes, belittling, social ridicule and insinuations (Ratele, 2008; Shefer et al., 2007). These behavioural patterns become so entrenched in social environments and culture; they create a powerful social structure that is used to judge men's "competence" based on ability to perform gender behavioural norms (West & Zimmerman, 1987).

The term "hegemonic masculinity" originated in the early 1980s (Connell, 1983) and refers to the most culturally valued form of masculinity characterised by gendered patterns of behaviours that uphold men's power over women. Hegemonic masculinity is argued to be a flexible, socially constructed and culturally exalted form of masculinity that represents power and authority and is reproduced through different social practices and day-to-day interactions (Bhana, 2009; Connell, 1995; Courtenay, 2000). Whilst various forms of masculinity exist, the aim to propel men to a position of power makes hegemonic masculinity the ideal form of masculinity that men are socialised to achieve (Beasley, 2008; Connell & Messerschmidt, 2005).

Seven dimensions of hegemonic male gender norms have been proposed: restrictive emotionality, self-reliance through mechanical skills, negativity toward sexual minorities, avoidance of femininity, importance of sex, toughness, and dominance (Levant et al., 2010). To demonstrate hegemonic masculinity, men are expected to observe these prescribed masculine gender roles that function to promote male dominance through subordination and distrust of femininity, resulting in the systematic oppression of women and less powerful men (Courtenay, 2000; Malamuth et al., 1991).

Hegemonic masculinity does not seek to characterise “real” men, rather it comprises behavioural principles that help guide and perpetuate men’s actions and is reinforced through interactions (Connell & Messerschmidt, 2005). Furthermore, hegemonic masculinity goes beyond overt domination of men over women, it also refers to the manner in which inequality in power is both normalised and taken-for-granted (Messerschmidt & Messner, 2018). An example of this is demonstrated in the findings of a study which revealed that among USA college students engaging in casual sexual encounters, it is normatively expected that men will achieve orgasm whilst there is no such expectation for women (Armstrong et al., 2012). Perpetuated by hegemonic masculinity, these inequalities promote more favourable outcomes for men yet remain invisible (Messerschmidt & Messner, 2018).

Masculinities have been directly and indirectly associated with risks STI and HIV risk (Lorimer et al., 2018). With dominant forms of masculinity manifested through heterosexuality and being sexually active, social constructions of masculinity in society are argued to impact men’s sexual health and relationships, with dominant forms of masculinity being associated with sexual risk taking, including condomless sex and multiple sexual partners to avoid social and public challenges to their masculine status (Connell, 1995; McDaid et al., 2019).

Condomless sex is argued to be promoted by dominant forms of masculinity as condoms represent a potential disruption to a man’s ability to perform sexually, with research suggesting that some men perceive condoms as interfering with the pleasure of sex and prevents them from achieving and sustaining an erection (Measor, 2006; Noar & Morokoff, 2002; Pleck et al., 1993). Sexual performance, including achieving and sustaining an erection can be vital in achieving masculine status, particularly amongst marginalised men, as being unable or unwilling to perform sexually with a woman could result in suspicions of homosexuality which prevent achieving the dominant ideal (Fleming et al., 2017).

Masculinity is argued to encourage sexual activity with multiple women as research suggests that men who abstain from or refuse sex with women experience challenges to their masculine status (Hyde et al., 2009). Also, sexual relationships are often depicted as a man’s conquering of a woman, thus having multiple women partners portrays a level of sexual prowess and control over women, both of which are signifiers of masculinity and consequently increase status and power over other men (Fleming et al., 2016).

Connell's (1983) hegemonic masculinity has attracted criticism for over-emphasis on certain forms of masculine power, including domination, subordination and oppression. This over-emphasis on power results in an equating of "power" with "domination" located in the hands of exemplary men and demonstrated in an overt and excessive manner. However, in reality, whilst many men benefit from the patriarchal dominance observed in society, systemic and institutionalised racism prevents Black men from demonstrating hegemonic characteristics thus suggests that hegemonic masculinity does not include or relate to Black men (Chaney, 2009).

Connell's (1983) hegemonic masculinity portrays the Black male experience more simply as the marginalised, disempowered "other" of heterosexual hegemonic masculinity, failing to acknowledge that there will be many situations where Black men hold less "power" than women. This is demonstrated in the findings of an intersectional analysis of pay differences in universities which revealed that White women earn significantly more than Black men in the higher education sector (Hopkins & Salvestrini, 2018). This highlights the importance of an intersectional approach when exploring traditionally gendered concepts among ethnic minorities.

An intersectional approach demonstrates how masculinity can interact with other socially constructed concepts including race, ethnicity and gender to challenge and disrupt male privilege by weakening the legitimacy of some men to the extent that they are unable to benefit from patriarchal dividend. Viewing gender through an intersectional lens highlights that being a Black man can present disempowerment and lack of privilege rather than the privileged benefits associated with patriarchy (Christensen & Jensen, 2014).

1.2 Intersectionality

'Intersectionality' was coined by American critical legal race scholar Kimberle Crenshaw (Crenshaw, 1989) and argues that race, gender, SES, and sexual orientation-based identities accompany us in all social interactions, with intersections between these identities creating complex social positions that are more dominant to the nature of social experiences than the inequality experienced as a result of single identities (Collins, 1993; Veenstra, 2011).

An intersectional approach enables one to better understand inequalities in three unique ways: firstly, it challenges the blanket assumption of similarities with sub-groups amongst

the population and highlights vital differences that are often hidden when adopting a universal approach to exploring the experiences and vulnerabilities of such groups. Secondly, it posits that social identities and structural disadvantages are interdependent, reinforcing and mutually constituting rather than just added together. Finally, it enables an analysis of the numerous sites and power structures that work together to socially disadvantage or privilege individuals and population groups (Kapilashrami, 2020).

Intersectionality has become popular as a theoretical framework in public health to aid understanding of health inequalities observed among marginalised populations as it highlights the ways that multiple axes of social inequality and discrimination intertwine at macro and micro levels to produce broad ranges of unequal outcomes at both individual and population health levels (Bates et al., 2009). An intersectional lens suggests that whilst health is an individualised experience shaped by individual factors and singular identities, individual health outcomes and inequities are inseparable from the interacting power structures at multiple levels (Hankivsky et al., 2017; Kapilashrami & Hankivsky, 2018).

Intersectionality as a theoretical framework has however attracted criticism for lack of guidance in its operationalisation, leading scholars to question how it can transform empirical research and translate findings into action to improve policy and practice. Critics have argued that as a theoretical perspective, it lacks methods that it can draw upon (Phoenix & Pattynama, 2006), fails to provide a sufficient underpinning for action to reduce health inequalities, and it was never intended to underpin health interventions, but to improve societal structures (Bird et al., 2012).

Intersectionality has received further criticism pertaining to its application to the experiences of Black men. It has been argued that intersectionality is unsuitable to the dilemmas of Black manhood as it fails to acknowledge the suffering, sexual discrimination and death of Black men, and presumptively ascribes male privilege to Black men suggesting that whilst Black men can be mistreated based on their race, the mistreatment of Black men cannot be underpinned by their sex (Oluwayomi, 2020). This inaccurate suggestion that Black men and boys are exempted from sexual discrimination because they happen to share generic indicators of privilege proposed by popular gender theories consequently means that whilst demonstrating how women have been negatively impacted by sexism, studies

have failed to appropriately examine how certain men also suffer from sexism (Curry, 2017; Orelus, 2010).

Black male studies scholars argue that in contrast to its promises for greater liberated Black identities, intersectionality has enabled Black women to create nuanced and epistemological accounts of Black womanhood whilst perpetuating racist criminological pseudo-scientific theories that confine Black masculinity to the perpetration of violence and the exemplification of White masculinity's pathological excess (Curry, 2021). As a result, intersectionality is said to lack the required epistemologies to appropriately catalogue the lived experiences of Black men and boys (Curry, 2019).

However, despite the concerns surrounding the origins of intersectionality and its applicability to the experiences of Black men, it has been argued that there should be less dispute about the tools themselves and more focus on what the tool is used to do (Táíwò, 2018). Ultimately, the gendered, racialised and economic factors that influence health disparities observed amongst Black men cannot be understood in isolation as they are inseparably linked and experienced simultaneously thus only an intersectional approach can ensure an exploration into how these relevant social factors intertwine uniquely to influence social experiences which affect health outcomes (Gilbert et al., 2016; Griffith, 2012). Particularly pertinent to Black men, race, gender, SES and sexual identity are not independent constructs that can be detached or ranked, rather, the constructs and their associated inequalities are mutually constituted to the extent that one cannot explore one social construct (e.g being Black) solely, absent from its intersection with another construct (e.g. SED) (Bowleg et al., 2017).

Regarding the operationalisation of intersectionality, it can also be argued that as a research paradigm, intersectionality is neither prescriptive, nor does it insist on the use of a particular research design but aims to evoke a shift in how researchers conceptualise social categories and their complex relationships and interactions, using this understanding to change how processes and mechanisms that form health disparities are interrogated (Dhamoon, 2011; Hancock, 2007). Relative to more established theoretical perspectives, despite intersectionality being in its infancy, applications of intersectionality are developing, with emerging research demonstrating that its foundations influence the way health disparities are conceptualised, studied and responded to (Krieger et al., 2010).

A strength of intersectionality is the way it enables conceptualisation of numerous categories of co-existing social identities, privilege and oppressions concurrently (Cole, 2009). For Black men, a fundamental social category contributing to their experiences is their race. Evidence indicates that intersectionality is essential to the racialised social processes which create and sustain the systemic racial inequalities Black men experience (Grzanka & Cole, 2022).

1.3 Black masculinity

Much has been written about the detrimental impact that conforming to traditional masculinity has on Black men due to the emphasis on material success which is difficult to obtain in the presence of structural barriers (J. L. White & Cones, 1999). With White, middle-aged, upper-class, heterosexual men enjoying the largest benefits of masculinity, scholars have argued that Black men attempt to regain masculinity through exaggerated sexual control over women, including having multiple sexual partners and higher rates of condomless sex due to their perceptions of condoms conflicting with their perceptions of sexual pleasure (Crook et al., 2009; hooks, 2004; Whitehead, 1997). Furthermore, positive sexual performances significantly contribute to achieving masculine status, particularly among Black men, who experience social and structural inequalities that are said to impede their ability to achieve masculine status through traditional behaviours (Carey et al., 2010). hooks (2004) argued that Black men must feel needed, feel as if they have purpose and feel in control thus they use sex and their bodies to achieve this as sexual spaces are the only spaces afforded to Black men where they can feel dominant, consequently making them feel like a man again.

These narratives have been argued to promote stereotypical and mythical narratives of Black men's sexual prowess underpinned by a longstanding misunderstanding of Black masculinity, sexuality and sexual experiences (Young, 2018). Previous literature has aimed to define Black masculinity in relation to traditional and mainstream eurocentric and patriarchal frameworks. Consequently, this fails to acknowledge the unique sociohistorical experiences and diversity of the Black male lived experience in a racial and cultural climate which justifies an exploration into how Black men define and interpret their masculinity (Mincey et al., 2014).

Much of the limited discourse on Black masculinity in a British context has been related to the poorer educational achievements of Black boys in an education system that positions them ambivalently by their teachers and peers, and results in negative perceptions of their masculinities and the pathologising of Black identities (Wright et al., 1998). Racist stereotypes have resulted in Black masculinity being portrayed negatively and associated with social problems like crime, deviance and unemployment (Archer & Yamashita, 2003), absent parenting and an unwillingness to take responsibility for their children (Reynolds, 2009). Similar stereotypes exist in the USA (Adams, 2001; Ferber, 2007; Gause, 2008; Smiley & Fakunle, 2016).

The pathologising of Black masculinity has been exacerbated by government policies that have implied the source of social problems amongst racially minoritised communities originated from their problematic cultural attitudes, behaviours and subcultures that were deemed to promote an "anti-education" masculine identity (Archer & Yamashita, 2003; Wright et al., 1998). These racist stereotypes have constructed Black men as hypermasculine, hyperaggressive and threatening which results in the increased monitoring and surveillance of Black men in public spaces (Reynolds, 2009). Where positive depictions of Black masculinity exist, these are often based on physical characteristics and athletic achievement (Frosh et al., 2000).

Scholars have proposed that Black masculinities are subjected to the exclusion of power and status associated with White masculinity which results in Black men reinventing identities demonstrating machismo whilst exerting power and control over others (Alexander, 1996). However, this has been met with criticism advocating that these statements reinforce negative stereotypes and a homogenous image of Black masculinity that is centred on aggression, violence and sexism when many Black men do not feel a need to mimic White patriarchy (Mirza, 1999; Wright et al., 1998).

With the limited literature on UK Black masculinity in the context of sexual behaviours, although unideal, there may be some benefit in looking towards USA based research due to the influence of Black American culture on UK Black culture and because far more research has been done in the USA. Moreover, the ethnic composition of the USA population also shares similarities to the UK in that majority ethnic groups are White whilst Black ethnic groups are racially minoritised (Phoenix & Husain, 2007). Additionally, similarly to Black

ethnic groups in the UK, Black Americans also experience structural inequalities including the lowest income and highest rates of poverty amongst all ethnic groups (Shrider et al., 2021), and have among the poorest outcomes for health (Radley et al., 2021), education (de Brey et al., 2019; Mocombe et al., 2017) and overrepresented in the criminal justice system (The Sentencing Project, 2018).

Young (2018 p.12) describes "blackness" as "an individual's experience as a Black person, specifically his or her experience and relation to the cultural norms, heritage, traditions, values, and history associated with Black culture". Whilst there are differences in the way the Black community in UK demonstrate their "blackness" to their American counterparts, UK blackness has been heavily influenced by Black American culture (Boakye, 2019) with some in the UK looking towards America to learn how to be Black in a world they feel does not value them (Katsha, 2018).

A study exploring associations between racial identity and risky sexual behaviours amongst 80 Black heterosexual men aged 18-29 years revealed that stronger positive feelings towards Black Americans was associated with fewer female sexual partners in the prior three months, and a stronger Black identity was associated with increased condom use and fewer casual sexual partners (Oparanozie et al., 2012). The findings contradicted suggestions that Black masculinity sees Black men redefine and embrace the hypermasculine label assigned to them as a way to combat racism (Messner, 1997).

Often overlooked are expressions from Black masculinity that are more mainstream and in line with European-American standards of manhood and focus on important roles like that of a provider, protector and disciplinarian (Pierre et al., 2001). Fatherhood is argued to be an essential aspect of Black masculinity in a USA context, however as in the UK, academic literature and popular media routinely emphasise absent Black fathers (Adams, 2001).

It is argued that the demonising of Black men sees them motivated to find alternative ways to express their masculinity and create a space to define themselves in (hooks, 2004). Whilst sex and sexual expression became one way of resisting White oppression, other Black men found opportunities for growth and progression through sports and athleticism (Young, 2018). However, the pathological homogenising of Black men has resulted in a limited,

unidimensional view of Black masculinity, measured against White men, resulting in a limited understanding of how Black men define their masculinity (Hunter & Davis, 1994).

Previous research revealed that Black men identified manhood as a multidimensional concept and categorised through self-determinism and accountability, pride, family, and spirituality and humanism (Hunter & Davis, 1992). These findings were also supported by a qualitative study of 24 Black men aged 18-51 years which revealed that Black men create their own version of manhood demonstrated by maturity, responsibility for self, responsibility for family, the provider role, and self-awareness (Chaney, 2009).

To avoid the assumption that Black men of differing identities have a fixed and definitive way of interpreting their masculine identities, it has been recommended that research should explore how Black men of different demographics define being a Black man and whether they perceive differences between their view of being a man and their view of being a Black man. This would suggest that simply exploring masculinity from a Black perspective limits true understanding of masculinity for Black men (Mincey et al., 2014).

To understand why heterosexual Black men are portrayed negatively, it is vital to acknowledge how racism and sexism combine to produce societal perceptions (Patton & Snyder-Yuly, 2007). Historically, blackness was associated with unrestrained sexuality resulting in the gender-specific assumption that heterosexual Black men were a threat to the sexual security of White women thus requiring White men to control and repress them (Cooper, 2006). Such attitudes have traditionally been used to defend the violent treatment of Black men in the form of brutal lynching's and other forms of murder for the purpose of protecting White women (Zounlome et al., 2021).

1.4 Black sexuality and sexual socialisation

Black male sexuality has a complicated history in the literature, with empirical information produced reactively in response to high rates of STIs rather than proactively with an aim to fully understand the cultural, contextual and personal factors that inform the construction or meaning of Black male sexuality (N. M. Hall et al., 2012).

Whilst masculinity plays a key role in acceptance and engagement in some unhealthy sexual behaviours, masculinity represents one of men's multiple identities and interacts with behavioural norms associated with other identities to vary the manner that gender norms

and masculine behaviours are performed (Fleming et al., 2016). This is particularly relevant to Black heterosexual men whose masculine practices are marginalised for less valued racial status.

Heterosexual identities have and continue to be constructed through race and racial formations, underpinned by racist discourses that perceive and portray blackness as hypersexual whilst whiteness is portrayed as unmarked and sexually normative (Dean, 2013). This produces the observed societal sexual image of Black men and perceived stereotype of Black male sexuality consisting of an exaggerated masculinity associated with early onset of sexual activity and multiple sex partners (Dean, 2013; Weinberg & Williams, 1988). Black male sexuality is more than a theoretical concept, it is historically rooted in struggles for social justice, with social inequality across intersections such as race, class and gender shaping how Black men experience and express their sexualities (Bowleg et al., 2017).

The empirical study of Black-British male sexuality is scarce, with much of the literature and our understanding of Black male sexuality originating from observations and research on Black American men. However, in the USA, behavioural science researchers have encountered challenges when researching Black male sexuality for reasons including, incorrect assumptions of homogeneity of sexual behaviours among Black men, emphasis on describing behaviour whilst failing to acknowledge the important contexts in which behaviour occurs for Black men and a quantitative focus on overt, observable and measurable problematic sexual behaviours (e.g. low condom usage and early sexual debut) whilst ignoring the meaning of these behaviours from the Black male perspective (Lewis & Kertzner, 2003).

Research from the USA indicates that the way Black men experience sexual socialisation significantly influences how they express their sexuality. Sexual socialisation, an intricate and multidimensional process through which young people learn and internalise knowledge, attitudes, skills, norms and expectations in relation to sexual relationships begins in childhood, increases in adolescence and continues throughout adulthood. It is a lifelong process in which people learn to be sexual within certain cultures and contexts (Ward, 2003).

With major socialising agents including families, schools, peers and mainstream media, any similarities observed in Black males' expression of sexuality can be arguably attributed the similar social constructions and systematic experiences Black men encounter (Lewis & Kertzner, 2003).

Through sexual socialisation, Black men acquire attitudes which become scripts that guide sexual behaviour throughout life. Whilst sexual socialisation is a universal experience that all experience, the learned and adopted norms and behaviours, alongside processes by which they are conveyed are not universal, but influenced by the social constructs including race, ethnicity, gender, and SES (L'Engle & Jackson, 2008), the same social constructs which disadvantage Black men in many other areas of life.

Whilst parents and peers are often cited as important sources of sexual information, they are not the only source and potentially not the most influential as research suggests that frequent exposure to sexually orientated content in the form of music videos is associated with increased acceptance of stereotypical and casual sexual attitudes and greater expectations about the prevalence of sexual activity (Ward, 2003). Technological advances in the production and broadcasting of Black popular culture is argued to have resulted in the glorification of urban street culture, particularly amongst young Black men who have an increased vulnerability in seeking social recognition and status amongst their peers (Oliver, 2006).

Dancehall music is said to locate its origins in the deprived neighbourhoods of Kingston, Jamaica in the 1970s and has emerged into a distinct musical, dance and fashion genre that enables individuals to assert a new sense of self and freedom (Stanley-Niaah, 2009; Woods, 2021). Hip-hop music is said to have also originated in the mid-1970s, but from the South Bronx neighbourhoods of New York, USA, initially providing a space for disenfranchised youth of colour to resist oppression (Alridge & Stewart, 2005). However, hip-hop and dancehall artists commonly glorify sex in their music and boast about sexual encounters with multiple women (Langley, 1994). This, coupled with the role model perception of the artists is said to teach young Black men that having sex is with multiple women is the ideal way to demonstrate manhood and one who does not abide by this is perceived to be less of a man (Staples, 2006).

Relationships and Sex Education (RSE) is capable of educating young people and promoting positive sexual health decision-making amongst young people, including the delayed onset of sexual activity (Rabbitte & Enriquez, 2019). Considering the changing context of young people's lives which includes increasing access to the internet and social media, the UK government introduced legislation which made RSE compulsory for all children aged 11 years and over (Department for Education, 2019).

Reports have highlighted that young people often find RSE irrelevant to their lives because they perceive RSE to be of a "negative" approach as opposed to a sex-positive approach, and it heavily emphasises on the biological elements of sexual health (Pound et al., 2016, 2017). Ironically, research has indicated that STI knowledge and condom use skills alone are insufficient at equipping young people with the resources to reduce their susceptibility to STIs (Gerressu et al., 2009).

A detailed understanding of where and when Black men obtain messages about sexuality, and how these messages influence their sexual behaviours is required (Hussen et al., 2012). In addition to musical content, the role of pornography on Black male masculinity must be discussed. Consuming pornography is related to adoption of sexually aggressive attitudes and behaviours, the acceptance of attitudes of violence against women, and learning of objectifying abstract sexual scripts such as those that promote the viewing of women as sex objects deserving of sexual aggression (Hald et al., 2010, 2013; Wright et al., 2015; Wright & Tokunaga, 2016).

Furthermore, Black men are often depicted as perpetrators of aggression against women and as less intimate with their partners than their White counterparts (Fritz et al., 2021). This matters as research has suggested that Black men are more likely to engage with pornographic content than all other race and gender combinations due to a combination of both racial and gender influences on Black male sexuality discouraging internalisation of various anti-pornography norms, whilst promoting accessibility and acceptability (Perry & Schleifer, 2019). The reasons behind the consumption of pornography by Black men, alongside how this influences their sexual experiences must be explored.

1.5 Rationale for current research and aims

Black men have been disproportionately represented in STI data and outcomes for decades (Daker-White & Barlow, 1997; Evans et al., 1998; FitzGerald et al., 1997; Sherrard & Bingham, 1995) and such disparities need to be addressed.

Research on the drivers of these inequalities and potential interventions is limited in the UK, with these having generally been conducted in an American context. A systematic review (Nwaosu et al., 2021) exploring whether psychosocial interventions are effective at increasing condom use among Black men reported that 16 of the 17 studies included in the review were conducted in the USA, with none conducted in the UK. Despite similarities in experiences between the UK Black population and Black Americans pertaining to socioeconomic disadvantage, health inequalities and exposure to structural and institutional racism, there are distinct differences in culture and access to health services (Gerver et al., 2011) therefore understanding from an American context cannot be organically applied to the UK Black population. The review called for future research to develop a better understanding of the sexual health experiences and motivators of Black heterosexual men in the UK to underpin culturally relevant and tailored interventions aiming to increase safer sex behaviours (Nwaosu et al., 2021). This study answers the recommendation of the review.

Research that does exist in a UK context has generally focussed on Black Caribbean men and revealed that they were more likely than White British men to report onset of sexual activity under 16 years, sexual concurrency, and multiple partners (Wayal, et al., 2018), and more likely to report greater partner numbers in the preceding three months (Aicken et al., 2020). Furthermore, when in concurrent sexual partnerships, condom use declines as the duration of the partnership and familiarity with partners increased (Wayal et al., 2020).

Moreover, these studies are particularly focused on specific health behaviours including condom use and concurrent sexual partnerships with limited understanding of cultural, contextual and personal factors that inform the meaning of Black male sexuality. Although this study is motivated by a desire to improve sexual health for Black men in the UK, including by increasing protective health behaviours and subsequently reducing STIs, it seeks a greater understanding of Black male sexuality than previous studies by aiming to

understand the social and psychological processes underpinning the sexual health experiences and motivators of Black heterosexual men, and explores the impact of racism on sexual behaviours and engagement with sexual health services.

This study focuses on Black heterosexual men as heterosexual Black Caribbean people are disproportionately affected by the main bacterial STIs (Gerver et al., 2011) whilst the HIV epidemic in the UK has largely been driven by HIV diagnoses amongst Black African heterosexual men and women (Rice et al., 2013). However, higher risk sexual behaviours are reported to be more prevalent amongst Black men than women (Coyle et al., 2018; Elam et al., 1999; Wayal, et al., 2018; Wayal et al., 2017).

Research is needed for a detailed understanding of the socioeconomic situations and sexual health preventative needs of Black heterosexual men (Dunlap et al., 2013) through in-depth qualitative studies. For interventions to be effective, a better understanding of the psychological processes which normalise and accept engagement in risky sexual behaviours is required (Kippax, 2008). Understanding influences on sexual behaviours can help underpin relevant and appropriate interventions, with success more likely to be achieved if interventions are tailored to meet the needs of the target population as demonstrated in the success of some HIV interventions amongst MSM (Bardsley et al., 2022; Hanum et al., 2020).

Specifically, Black heterosexual men in London were the focus of this study as data has revealed that London had the highest rate of new STIs in England (Public Health England, 2019b). Furthermore, a limited amount of research has been conducted amongst Black heterosexual men in London despite the reported influence living in London has on sexual behaviours. Alongside significantly influencing the dynamics of their sexual networks, among second and third generation ethnic minorities, the shared education, societal experiences and influences associated with being London born and educated may result in peer, urban youth culture through acculturation being more influential than ethnic based cultural influences on sexual health beliefs and behaviours (Connell et al., 2001). This argument is supported by the findings of a later qualitative study (Connell et al., 2004) investigating ethnic differences in sexual health amongst 42 young Black Caribbean, Black African and White ethnicities. The findings revealed more within-group similarity than between-ethnicity difference, with few differences in norms reported by participants, of

varying ethnicities, but mostly born and educated in London. The researchers concluded by arguing that similarities in reported norms for all ethnic groups may be related to common social and cultural exposures. Another study (Gerressu, 2016) exploring factors that exacerbate STI risk among Black British/Caribbean young men in North-West London revealed that ethnicity alone, displayed as cultural influences did not determine sexual behaviours, but rather the power of local area, peers and neighbourhood norms were influential on detrimental sexual behaviours and beliefs.

Whilst the above studies were conducted among young Black men, research has highlighted that cultural and social factors also influence behaviours that increase susceptibility to poor sexual health outcomes among adult Black men, with individual sexual health outcomes largely susceptible to influence by social environment because of interplay between numerous factors including ethnicity, socioeconomic status, SED and masculinity (Baker et al., 2012). It is therefore vital to understand Black heterosexual male issues within the context of localised neighbourhood cultures to develop a holistic picture of their experiences as place of residence influences the constant reproduction of gendered, classed and racial inequalities (Gunter, 2008).

London also afforded access to a wide variety of experiences as 58.4% of the UK Black population reside in London (Office for National Statistics, 2020).

This research aims to develop a greater understanding of the sexual health experiences and motivators of Black heterosexual men, by answering the following questions:

1. What does it mean to be a man?
2. How does the experience and understanding of being a Black man inform sexual attitudes, relationships and behaviours?
3. What do Black heterosexual men describe as their motivators for condom use and how does this inform their STI and pregnancy prevention efforts?
4. What is the experience of racism among Black heterosexual men and how does this experience inform engagement with sexual health services and interventions?

This study was limited to cisgendered heterosexual men. Whilst transgender children are socially transitioning at an earlier age (Hill et al., 2010; Malpas, 2011), there are unique

differences from their cisgender peers in the way they experience socialisation considering their experience of living part of their childhood treated as members of one gender before transitioning (Gülgöz et al., 2019). Furthermore, public health authorities suggest including transgender men in STI prevention interventions that target women due to similarities in anatomy (UK Health Security Agency, 2022).

This research contributes to the emerging literature by exploring the sexual health experiences and motivators of a marginalised population, Black heterosexual men in London. Understanding the thought processes that underpin unhealthy sexual behaviours, motivators of protective sexual behaviours, and factors encouraging engaging with sexual health services can help develop local profiles of psychosocial influences on sexual behaviours which are significant to developing tailored, culturally appropriate interventions that aim to reduce poor sexual health outcomes among Black heterosexual men.

2.0 Methodology

This chapter will describe the design and methods used to answer the study question alongside the rationale for their selection.

2.1 Design

It has been argued that a good research study begins with identification of a topic, problem or area of interest, alongside a research paradigm (Groenewald, 2004). A research paradigm is described as a belief system and framework with assumptions regarding ontological, epistemological and methodological concerns (Rehman & Alharthi, 2016).

2.2 Ontological and epistemological positioning

Ontology refers to the claim researchers assert regarding knowledge, the world being investigated and the nature of reality (Crotty, 2003). Ontological positions initiate the process of knowing and describe entities that can be said to exist alongside the nature of relationships that exist among basic categories of being (Guba & Lincoln, 1989). On the other hand, epistemology is “a way of understanding and explaining how we know what we know” (Crotty, 2003 p.3) and provides researchers with a philosophical grounding for the types of knowledge that are possible, and how we can ensure both adequacy and legitimacy (Maynard, 1994).

There are two widely acknowledged ontological positions, positivism and interpretivism (Berryman, 2019). Generally, positivist researchers believe that truth is discoverable but independent from human consciousness and it is possible to discover cause and effect relationships between phenomena using repeated observations (Kincheloe & Tobin, 2009). The positivist researcher will therefore ask questions that can be quantified (Berryman, 2019). However, the ontological view taken in this study aligns with the interpretivist position which asserts that there are multiple truths which are revealed through social constructions, language, shared consciousness and other social interactions (Weber, 2004). With an interest in understanding and meaning, rather than cause and effect, interpretivist researchers ask questions that seek to understand the how and why (Maxwell, 2008). These ontological assumptions informed the approach taken in this study and enabled the capturing of the lived experiences and worldview of participants and supported the epistemological positioning of this study.

This research was underpinned by a constructivist epistemology, that there is a multidimensional nature to reality that needs to be explored and interpreted to make sense of meanings of events. This study was informed by the assertion that truth and meaning are constructed rather than discovered, and that people construct meaning in different ways, even in relation to the same phenomena (James & Busher, 2009). The epistemological positioning underpinning this study rejects the objectivist epistemology which holds that there is an objective reality and research is about discovering objective truth using a rigorous process of scientific inquiry which disregards the researchers own feelings and values (Gray, 2013). The constructivist epistemological position was suitable for this study and placed the participants' voices at the centre of the exploration.

2.3 Methods

The interpretivist/constructivist ontological and epistemological positioning aligned with this study's aim of obtaining an in-depth understanding of the sexual health behavioural experiences and motivators of Black heterosexual men in London. A qualitative approach also enabled centring the participant's voices and experiences (Mauthner et al., 2002). Qualitative methodology is aligned to social constructionism as it rejects the notion that knowledge is an objective reality and disagrees with the positivist paradigm, where knowledge consists of verified hypotheses which enable researchers to predict and control

the phenomena under investigation (Launer, 1996; von Wright, 1971). The nature of qualitative research results in researchers obtaining more information about the target phenomenon as qualitative research aims to understand human experiences and the meaning attached to human action in a humanistic and interpretive manner (Denzin & Lincoln, 2000).

Many qualitative approaches facilitate deep exploration of concepts and acquisition of meaningful understanding; however, a phenomenological approach was adopted as it has been identified as the most appropriate method for an in-depth exploration of personal meanings of individual's lived experiences and behaviours (Polgar & Thomas, 2000; Rossman & Rallis, 2003). Phenomenology is described as a multifaceted philosophy and approach to qualitative research that is centred on the study of an individual's lived experiences within the world (Neubauer et al., 2019). With particular focus on experiences and meanings, phenomenologists reject the legitimacy of knowledge that is obtained whilst ignoring the perceived world of everyday human experience and aim to capture the way in which phenomena are experienced in context (Crotty, 1998; Giorgi & Giorgi, 2003). This is particularly important for race-related and sexual health research as individual subjective experiences are inextricably linked with their social, cultural and political contexts, therefore, interpreting narratives in relation to their contexts illustrate essential structures of participants' understanding of being and how this influenced their decision making (Heidegger, 1962; Neubauer et al., 2019).

2.4 Data collection method

2.4.1 Interviews

Interviewing is a widely used data collection method in qualitative social research where researchers aim to explore phenomena (Robson, 2011). Interviews are recognised as a thought-provoking method of enabling respondents to interpret and share their knowledge and experiences (Holstein & Gubrium, 2003). Qualitative researchers identify interviews as useful for eliciting data related to perceptions, beliefs and experiences, and exploring past or present behaviours, feelings and explanations (Silverman, 1993).

One-to-one interviews were identified as the most appropriate data collection method to obtain rich and meaningful data of the phenomena whilst providing participants with a safe

and non-judgemental space to openly discuss experiences of sex and relationships, a sensitive topic of investigation (Anderson et al., 2009; Sim & Waterfield, 2019). Whilst group interviews and focus groups could have been used for data collection and can encourage better interaction and dialogue from participants, these are discouraged for sensitive topics where participants could experience social stigmatisation because of disclosures that may contradict accepted social norms (Nyumba et al., 2018).

2.4.2 Semi-structured interviews

Qualitative interviews can be conducted in a structured, semi-structured or unstructured manner (Mann, 2016). Structured interviews see researchers follow a predetermined and standardised series of questions which allow for limited responses (Qu & Dumay, 2011).They are useful for offering the same stimulus to each participant to obtain responses that are comparable (Berg, 1998). Contrastingly, unstructured interviews are unique to the individual and context and aim to make participants feel relaxed and unassessed, enabling collection of rich data through informal conversations (Hannabuss, 1996).

Scholars have suggested that semi-structured interviews are often the most effective and convenient qualitative data collection method as it enables the interviewer to modify the style, pace and order of questions to obtain the richest responses from participants and can uncover important and hidden aspects of human behaviour (Kvale & Brinkmann, 2009). More importantly, semi-structured interviews enable participants to express their own way of defining the world and respond in their own terms, in the way that they think (Robson, 2011).

The use of semi-structured interviews in sexual health research is not uncommon. In a study to understand attitudes towards, typologies, and drivers of concurrent partnerships among people of Black Caribbean ethnicity in England, semi-structured interviews were used to explore personal experiences (Wayal et al., 2020). Similarly, a qualitative study exploring factors that exacerbate STI risk among Black British/Caribbean young men used both semi-structured interviews and focus groups as their data collection method. However, the interviews yielded more detailed and personal data than data obtained through focus groups because of the influential presence of peers within the groups (Gerressu, 2016).

Semi-structured interviews was chosen as the data collection method for this study as this enabled exploration of narratives that participants chose to share, and acquisition of a rich understanding of the meaning participants assigned to their experiences, motivators and behaviours. Semi-structured interviews enjoy popularity due to the flexible, accessible and intelligible nature of the approach whilst less flexible approaches are said to constrain the development of rapport between the interviewer and participant (Fowler & Mangione, 1990; Qu & Dumay, 2011). Rapport between researcher and participants is said to heighten participant disclosures of their experiences (Dickson-Swift et al., 2007).

2.4.3 Interview topic guide

The interview guide was used as a checklist for topics to be covered and a tool to aid the flow of the interview, whilst providing flexibility and opportunities for elaboration and clarification of questions and responses.

The interview guide (appendix B) for this study was developed to cover various themes about the sexual health experiences of Black heterosexual men and underpinned by previous studies (Gerressu, 2016; Wayal et al., 2020) which qualitatively explored attitudes and drivers of sexual behaviours among men of Black British and Black Caribbean ethnicities in London, but adapted for relevance to the aims of this study.

With consideration to the sensitive topic being discussed, the interview guide was intentionally designed to begin with rapport building discussions to help participants feel at ease. Previous sexual behaviours research has documented the success and value of starting interviews with less threatening topics such as the participant's social and demographic background and experiences of sex and relationships education (Elam & Fenton, 2003).

Table 1: Interview guide headings

Introductions
Background, general information, hobbies and interests
Experience of growing up in London
Experience and sources of sex and relationships education

Impact of London on views and perceptions of sex
Peer norms and perceptions on sexual behaviours
Experience of having multiple sexual partners
Condom use experience and motivators
Masculinity
Black masculinity
Experiences of racism
Experience of sexual health services
Debrief and closing comments

A section of the interview was dedicated to exploring participants' experiences of racism as the experience of racism in society generally, and specifically within healthcare settings can influence people's perceptions of the healthcare system, how they engage with health services and whether individuals adhere with practitioner recommendations (Williams & Mohammed, 2009). With a previous study reporting perceptions of inappropriate sexual health services and long-standing feelings of discrimination towards Black people within sexual health services (Connell et al., 2001), a section exploring experiences of accessing sexual health services was also included in the interview.

2.5 Participants

2.5.1 Patient and Public Involvement (PPI)

PPI in research involves planning research with members of the public rather than solely conducting research on them, and is based on the fundamental belief that people who are affected by research possess a right to contribute to how the research is conducted, including how the findings are disseminated (Bagley et al., 2016). It is argued that the unique perspectives brought by the actively involved public can result in greater quality research and can improve the way in which research is prioritised, conducted, communicated and used (Brett et al., 2014).

A PPI group was established to support this study in a project advisory capacity. The group consisted of 6 Black men residing across London. Age within the group ranged between 23-31 years, and employment status ranged between unemployed, self-employed, employed in

skilled and professional labour. A WhatsApp group was launched to facilitate instant and convenient communication between the group and sharing of resources in various formats.

The group were consulted on key aspects of the research including design of the recruitment poster, identification and selection of recruitment sites, appropriateness of the interview guide, interview method (face-to-face or virtual), and dissemination of findings. For example, in designing the study recruitment poster (appendix C), the graphic designer shared various initial designs and concepts with the group for opinions. The group expressed an importance of the poster containing pictures of real Black men rather than cartoon imagery. The group also included a barber who advised on barbershop-related logistical aspects of recruitment.

2.5.2 Sample

An inclusion and exclusion criteria was devised to ensure the study sample adhered to the aims of this study. The inclusion and exclusion criteria is demonstrated in Table 2.

Table 2: Participant inclusion and exclusion criteria

Inclusion Criteria	Exclusion criteria
Aged 18+ years	Under 18 years
Self-identifies as Black British, Black African, Black Caribbean or Black Other ethnicity	Fails to declare ethnicity or does not identify as of Black ethnicity
Cisgendered man	Identifies as transgender, non-binary or a woman
Engages in sexual activity with women only	Men who have sex with men, and men who have sex with men and women
Has current or prior experience of engaging in condomless and condom-protected sexual intercourse	Has never engaged in sexual intercourse or only ever engaged in condomless sex or condom-protected sex
Has current or prior experience of having concurrent sexual partnerships	Has no experience of concurrent sexual partnerships
Good level of English speaking and reading ability	Does not possess a good level of English speaking and reading ability

The recruitment process occurred between August 2020 and February 2021. Several locations were considered for recruitment including sexual health clinics, shopping centres, nightclubs and social events.

This study avoided recruiting participants from sexual health clinics for two reasons. Firstly, to ensure the experiences of those who may have disengaged from mainstream services could be captured. Secondly, challenges to the recruitment of racially minoritised populations to research exist and include social stigma associated with some conditions, mistrust, fear and lack of confidence in researchers, and lengthy consent documents (Haley et al., 2017; Hussain-Gambles et al., 2004; Mills et al., 2006).

Ultimately, barbershops were chosen as the recruitment location as within the Black community, barbershops are longstanding integral and culturally specific discursive spaces of intrinsic value (Alexander, 2003). In the USA, Black barbershops are viewed as a cultural institutions that regularly attract significant numbers of Black men, serving as meeting places for Black men from all socioeconomic backgrounds to congregate and openly discuss several topics with peers (Balls-Berry et al., 2015; Releford et al., 2010). This intrinsic valuing of barbershops has also been observed among UK Black men with research suggesting that Black men are significantly more likely to attend barbershops for reasons other than hair, with socialising and talking identified as a major ulterior motive for attending (Roper & Barry, 2016). Major topics of discussion in barbershops among UK Black men included "health" and "personal issues" (Barry & Roper, 2016). Barbershops therefore provided access to Black men who may not be accessed at mainstream health services like sexual health clinics or commercial and social venues like nightclubs and social gatherings.

There is much debate and uncertainty concerning adequate sample sizes for qualitative studies (Vasileiou et al., 2018). Scholars argue that there is no straightforward answer to this debate, and sample size depends on various epistemological, methodological and practical issues, with sample sizes large enough to elicit a new and rich understanding of the phenomenon, but small enough to facilitate a deep, case-orientated analysis (Baker & Edwards, 2012; Sandelowski, 1995). It is well documented that phenomenological studies require less participants than other qualitative methodologies, with a maximum of 10 interviews suggested, and an ideal number towards the top of that suggestion (Moser &

Korstjens, 2018). This is supported by Creswell (1998) who suggests long interviews with 10 participants for a phenomenological study.

A sample of 10 participants was recruited in line with suggestions for phenomenological sample sizes and logistical and practical parameters, including study timescale and financial restraints. All participants identified as heterosexual, cis-gendered men of Black or Black British ethnicity. Black ethnic groups include 'Black African', 'Black Caribbean' and 'Black Other' ethnicities (Wayal, et al., 2018).

This study recruited participants based on their self-identified race/ethnicity. Race and ethnicity are regarded as complex and personal concepts which are largely informed by factors including shared traditions and practices, place of birth, religion and language (Race Disparity Unit, 2021). Whilst there is a growing call for researchers to acknowledge socially assigned race, the perception of one's race by others (White et al., 2020), ultimately, the complex and subjective nature of race and ethnicity means the most practical way of collecting information about people's race and ethnicity is to use self-reported data (Race Disparity Unit, 2021).

In this study, an active effort was made to avoid further imposing socially assigned racial labels on people and allow those who self-identify as being of Black ethnicity to express their interest in participating in this study. Furthermore, studies exploring identity may benefit from using self-identified race/ethnicity as these concepts are reported to be important for self-identity due to the sense of connection encouraged with a certain group's cultural values, kinship, and beliefs (Phinney, 1996). This was vital in this study as various aspects of Black identity underpinned participants' experiences.

A well-selected sample is vital in maximising the range of experiences of the phenomena being explored (Singh, 2004). To facilitate this, a combination of snowball and purposive sampling strategies were adopted.

During snowball sampling, researchers identify a small number of individuals who possess the demographic and experiential characteristics of the phenomena being explored. These individuals then help to identify and contact others who also meet the study eligibility criteria. Snowball sampling is recommended where access to participants may be

challenging or where the phenomena being explored is of a sensitive nature (Cohen et al., 2000). However, snowball sampling may result in the sample reflecting a type of individual from the targeted group rather than providing a sample with a range of experiences and allowing for hearing a wide variety of accounts (Cohen et al., 2011).

In this study, three barbers with large customer bases and social media followings were identified to serve as informants. To acquire depth and diversity in perspectives relative to the phenomenon being explored, a maximum variation purposive sampling strategy was also adopted (Benoot et al., 2016).

2.5.3 Participant demographics

Participants provided demographic information including age, ethnicity, educational attainment, employment status, place of birth and current relationship status. As discussed in the previous section, a purposive sampling strategy was adopted to ensure a variety of accounts were collected. As a result, variation across several demographic factors enabled access to a wide account of experiences. Full demographic information can be found in Table 3.

Participants will be referred to using their self-chosen pseudonyms to maintain anonymity and confidentiality.

Participants were aged between 18–58 years. The mean age was 36 years.

Self-identified ethnicity varied across the sample between Black African (n=4), Black Caribbean (n=3), mixed Black African and Caribbean (n=1) and Black British (n=2).

Most participants (n=8) identified as “working class” whilst one participant identified as “between working and middle class”. One participant, Marvin identified as a different socioeconomic class, “migrant class” and shared his rationale for identifying this way:

> *I think that there is another class though, whose loyalties remain with the working class, but we're a migrant class. Where I lived when I was a kid, and the kind of poverty that existed in that community, the Black people there were poor because we were migrants, and we would have been poor migrants wherever we went.* (Marvin, 58)

Alongside residing in London, most (n=9) of participants were also born in London, with the sole non-London born participant being born in Kenya but moving to London as a toddler.

Current relationship status varied across the sample between “single” (n=6), “married” (n=2), “common law partnership” (n=1) and “on a break” (n=1). Six participants reported being a father, of which, all reported having a daughter whilst three also had sons.

The highest level of educational attainment was bachelor’s degree level with five participants reporting being educated to degree level.

Table 3: Participant demographics

Alias	Ethnicity	Age	Educational attainment	Employment status and type	Socioeconomic status	Birthplace	Area of residence	Relationship status	Children
Anton	Black Caribbean	29	Bachelor's degree	Employed - professional	Working class	London, UK	NW London	Single	1 son 1 daughter
Jay-Jay	Black African	37	Bachelor's degree	Employed - professional	Working class	London, UK	SW London	Single	1 daughter
Daniel	Mixed – Black African and Caribbean	24	Bachelor's degree	Unemployed	Working class	London, UK	E London	Single	None
Kamal	Black African	18	GCSE's	Unemployed	Working class	London, UK	W London	Single	None
Marvin	Black Caribbean	58	Bachelor's degree	Employed - managerial	Migrant class	London, UK	SE London	Married	2 sons 1 daughter
Simon	Black British	50	GCSE's	Employed - professional	Working class	London, UK	E London	Married	1 son 1 daughter
Martin	Black African	41	NVQ Level 3	Employed - labour	Working class	Kenya	E London	Common law spouse	1 daughter
Ryan	Black Caribbean	34	Bachelor's degree	Unemployed	Working class	London, UK	Hertfordshire	Single	None
Dwayne	Black British	46	GCSE's	Employed - managerial	Working class	London, UK	N London	Single	1 daughter
Ashley	Black African	20	NVQ Level 2	Employed - labour	Working/middle	London, UK	E London	On a break	None

GCSE: General Certificate of Secondary Education; NVQ: National Vocational Qualification; E: East; NW: Northwest; SE: Southeast; SW: Southwest; W: West

2.6 Procedure

2.6.1 Recruitment

Initially, participants were recruited through three barbershops: one in South London, one in East London and one in West London. Barbershops were contacted and asked to display the recruitment poster in a visible location within their shop. Barbers were also asked to alert eligible customers of the study. A barcode was added to the poster to take participants directly to the study registration page on the Qualtrics website where participants could access the study information sheet (appendix D) and privacy notice (appendix E), register interest in participating, complete a consent form (appendix F) and schedule an initial telephone consultation.

As COVID-19 restrictions resulted in the closure of barbershops for significant periods, a change in recruitment strategy was enforced. Barbers were subsequently asked to share an image format of the poster on their respective social media platforms accompanied by a website link to the study registration page to enable customers to express an interest in participation.

2.6.2 Initial contact and obtaining informed consent

Individuals who registered to participate were contacted for an initial telephone consultation. These individuals will be referred to as “registrants” to distinguish between those who expressed an interest and those who proceeded to be interviewed. During the initial telephone consultation, I engaged registrants in an informal conversation, introduced myself and built rapport. This initial consultation was also used to explain the research rationale, aims, objectives and implications for practice, and elicit demographic information to ensure eligibility and to encourage the study purposive sampling strategy.

After this initial consultation, some registrants decided against participating for various reasons including underestimation of interview requirements and limited availability. Some registrants were not progressed to the interview stage due to limited sexual experience including recent sexual debut. Finally, some registrants were not progressed to the interview stage due to similar demographics to participants that had already been interviewed.

Registrants progressing to interview participation were asked to confirm their consent to participate and reminded of their rights to withdraw. An interview date and time was agreed, and I reminded participants of the requirement to be able to access a mobile device or tablet with access to internet and good network coverage.

2.6.3 Interviews

The first interview was conducted in September 2020. Microsoft Teams was used to conduct and record all interviews due to government-imposed COVID-19 restrictions on household mixing.

At the beginning of interviews, I reintroduced myself and thanked participants for agreeing to be interviewed. Participants were reminded of the voluntary and confidential nature of their participation, their right to withdraw from the study and confidentiality limitations in the event of disclosures suggestive of risk of harm. Whilst participants were offered the opportunity to deactivate their camera for comfortability, no participants exercised this offer. Initial rapport building questions about daily lives, hobbies and interests followed, helping participants to settle into the interview and minimising the power imbalance to encourage a conversational dynamic rather than one of an official interview.

My approach to the interviews was consistent with interview guidance (Arksey & Knight, 1999, p.53) which suggests that researchers should: (1) appear interested; (2) adhere to the interview schedule if conducting semi-structured interviews; (3) avoid signalling approval or disapproval of responses; (4) be prepared to repeat questions if requested; (5) be prepared to proceed to another question without irritation should the respondent indicate unwillingness or inability to answer the questions; (6) ensure researcher understanding of responses; (7) thank the respondent and ask for elaboration if a response is inadequate but the interviewer feels that the respondent may have more to say; and, (8) allow the respondent sufficient time to answer (avoiding answering the question for the respondent).

Interview durations ranged between 1 hour 11 minutes and 2 hours 2 minutes, and progressed through a discussion of topics. The sequence of discussion varied between participants and was largely led by the participant's responses. Interviews were audio-recorded using the inbuilt function on Microsoft Teams to enable transcription and analysis of data. I was mindful to inform participants when I would start recording and advised them

to refrain from mentioning identifiable details like their name or place of work. Upon conclusion of the interview, participants were debriefed, including information about how to withdraw from the study and where to access further support.

Interview audio was uploaded onto a secure folder on my university assigned OneDrive and securely deleted from my personal laptop. Access to the interview data was shared with two other individuals with supervisory responsibilities.

2.7 Data analysis

2.7.1 Thematic analysis

This study adopted a thematic analysis (TA) framework to analyse obtained data, explore and identify patterns, and draw interpretations from the data. TA, described as "a method for identifying, analysing and reporting patterns within data" (Braun & Clarke, 2006, p.79), is widely recognised as an appropriate method for acquiring and providing a comprehensive account of qualitative data. Furthermore, the TA method aligned with the aims of this study as TA has been described as an appropriate method of analysis for seeking to understand experiences, thoughts, or behaviours across a data set (Braun & Clarke, 2012; Kiger & Varpio, 2020).

TA is argued to be a highly flexible method that can be widely used across a variety of epistemologies and research questions, adapted to the needs of many studies whilst maintaining the ability to provide a rich and detailed, yet complex account of data (King, 2004; Nowell et al., 2017).

Braun & Clarke (2019) now label their approach as reflexive thematic analysis (RTA) due to variation in procedures and underlying philosophy with other TA approaches. Since initially writing on TA (Braun & Clarke, 2006), the method has become significantly popular amongst qualitative researchers and the variety of TA approaches have expanded resulting in TA being clarified as an umbrella term – for approaches with some similarities in characteristics, alongside variations in underlying research values, conceptualisation of core constructs and analytic procedures – rather than a single analytic approach (Braun et al., 2019).

In a methodological paper, Braun & Clarke (2021) describe their categorisation of TA methods into three broad types:

1. Coding reliability approaches adopt a structured approach to coding underpinned by a coding frame and involve early theme development, conceptualisation of coding as a process of identifying evidence for themes and presentation of themes as an overview of frequently mentioned things in relation to a particular topic or question.
2. Reflexive approaches involve later theme development requiring considerable analytic and interpretative work from the researcher to develop codes into themes conceptualised as patterns of shared meaning, united by a core concept (Braun et al., 2015).
3. Codebook approaches combine the structured approach to coding prominent in coding reliability approaches with the research values of reflexive approaches to chart and map the developing analysis.

Specifically, this study adopted an RTA approach, argued to provide researchers with a robust, systematic framework for coding qualitative data to subsequently identify patterns across the dataset pertaining to the research question (Braun & Clarke, 2014).

Whilst the origins of TA can be located in the practice of qualitative content analysis, it has been argued that RTA should be considered a standalone analytic method because the theoretical freedom offered by RTA consequently results in a more accessible method for identifying, analysing, organising, describing, and reporting themes found within a dataset (Braun & Clarke, 2006; Smith, 2000).

A theme is described as “something important about the data in relation to the research question, and represents some level of patterned response or meaning within the dataset” (Braun & Clarke, 2006, p.82).

In the analysis stage, themes can be classified as either semantic or latent (Kiger & Varpio, 2020). Semantic themes are said to be the simplest type of themes and address surface meanings of data, often when the researcher is primarily focused on what has been explicitly said or written by the participants. On the other hand, latent themes go beyond surface level descriptions and require the researcher’s interpretation to reflect deeper and more underlying connotations, assumptions or ideologies to create a theory based on the importance of patterns (Boyatzis, 1998; Braun & Clarke, 2006). Whilst the researcher is afforded the flexibility to decide which themes to construct, themes should be important

and provide insights that are relevant to the research question (Kiger & Varpio, 2020). In this study, the theme construction process progressed from a semantic to a latent level to reflect deeper understanding and meaning of the sexual health experiences and motivators of participants.

Researchers can adopt an inductive 'bottom-up' or deductive 'top-down' approach to RTA (Braun & Clarke, 2012). An inductive analysis derives themes from the researcher's data whereas a deductive analysis uses a pre-determined theory or framework to develop themes of interest (Varpio et al., 2020). An inductive approach is said to produce a larger and more expansive analysis of the entire data set, whereas a deductive approach is beneficial when emphasis is on a particular aspect of the data or a specific finding that is best highlighted in the context of a pre-existing theory (Braun & Clarke, 2006). This study adopted an inductive approach to enable detailed analysis and theme development free of pre-existing theoretical assumptions.

Braun & Clarke (2006) outline a six-phase process for conducting RTA as follows:

1. **Familiarisation with the data** – this phase requires the researcher to immerse themselves in the data and involves transcribing, reading and re-reading the data with the aim of becoming intimately familiar with the content.
2. **Generating initial codes** – this phase involves identifying potential data items of interest, questions or concern that might be relevant to answering the research question. This involves coding the entire dataset and subsequently collating all codes and relevant data extracts for later stages of analysis.
3. **Generating initial themes** – this phase involves examination of the coded and collated data extracts to identify potential themes of broader significance and meaning.
4. **Reviewing themes** – a two-step process that involves reviewing themes against the dataset to ensure coherence and a meaningful fit, and determining whether themes accurately represent the entire dataset. This phase typically requires themes to be refined which can result in themes being combined, split, or disregarded.
5. **Defining and naming themes** – this phase involves a detailed analysis of themes to create a definition and determine the scope, focus and narrative of each theme. An informative name is applied to each theme.

6. **Writing the report** – this phase involves writing up the final analysis and weaving of a narrative that provides a clear, concise, and logical contextualisation of the data with detailed examples.

Whilst the phases are sequential, Braun et al. (2015) advise that TA should be conducted in a recursive, as opposed to a linear manner, enabling codes to be extracted and transformed into themes, and validated through frequent reference to the extracted codes and entire data set. To enable a rigorous analysis of data, the researcher is required to move back and forth between different phases of the process in the light of new data or newly constructed themes meriting further investigation (Kiger & Varpio, 2020). Good quality RTA requires significant reflective and thoughtful engagement with the data and analytic process (Braun & Clarke, 2019). The recursive process of RTA followed in this study is outlined in Table 3.

Table 4: Phases of thematic analysis undertaken in this study

Thematic analysis phases	**Steps of analysis**
Phase 1: Familiarisation with the data	Audio recordings were listened to in full. Audio recordings were then initially transcribed verbatim but then transcribed intelligently, omitting fillers like “erm” after five interviews were transcribed. Transcripts were read repeatedly alongside listening to audio recordings to ensure accuracy and familiarisation with data. Initial thoughts on potential codes were noted.
Phase 2: Generating initial codes	Interview transcripts were uploaded onto Nvivo 1.5. Codes were generated inductively from the transcripts. A non-linear recursive and reflective process was followed.

	Initial codes (appendix G) were collated, exported to Microsoft Word and sent to supervisory team for review. Entire dataset was recoded to demonstrate progression from semantic to latent analysis (appendix H).
Phase 3: Generating initial themes	Codes were examined and exported to Microsoft Word to be printed and manually organised into broader themes of significance and meaning. Initial themes were sent to the supervisory team for review.
Phase 4: Reviewing themes	Themes were refined to ensure representation of the data set. Subthemes were created and some themes merged and disregarded. Dataset was examined to produce names for themes that were reflective of participants' voices
Phase 5: Defining and naming themes	Overarching themes and subthemes were further refined and allocated definitions to ensure a clear scope for each theme. Theme names were further refined to demonstrate clarity and a latent analysis. Braun & Clarke (2006) 15-point checklist (appendix I) was used to ensure quality and a rich analytic narrative informed by the dataset.
Phase 6: Writing the report	The report was written to contextualise the narrative accounts under main themes and subthemes supported by extracts.

2.8 Alternative qualitative methodologies considered

Whilst TA has received significant popularity due to the highly flexible and accessible nature of the method (King, 2004), the method has attracted criticism for lack of clarity and literature on how to conduct a rigorous TA in comparison with other qualitative methods including grounded theory and ethnography (Nowell et al., 2017). It has been argued that this lack of substantial literature can destroy the value and validity of TA, resulting in findings with low level analytical narratives that simply paraphrase data content and a lack of proportionality, coherence and consistency between themes and the data (Javadi & Zarea, 2016). Braun & Clarke (2006) attempted to address the limited guidance on how to conduct a rigorous TA by producing a detailed step-by-step six-phase guidance. Furthermore, Holloway & Todres (2003) argue that concerns surrounding consistency and cohesion can be alleviated by explicitly stating the epistemological position underpinning the study's empirical claims.

A grounded-theory approach was considered, however, the aim of this research did not align with the goal of grounded theory, to "develop an explanatory theory of basic social processes, studied in the environments in which they take place" (Glaser & Strauss, 1967). Rather, this study was focussed on obtaining a deeper understanding of lived experiences through embodied perception and by exploring taken-for-granted assumptions about these ways of knowing (Sokolowski, 2000).

An interpretative phenomenological analysis (IPA) methodology was also considered to guide this study. Stemming from phenomenological origins, the approach has become increasingly popular in health psychology research and aims to thoroughly explore processes in which participants rationalise their own experiences and understand the subjective views, perceptions and meanings individuals attach to experiences (Brocki & Wearden, 2006; Reid et al., 2005; Smith, 1996). However, whilst TA serves as a flexible analysis approach that can be used across a variety of theoretical frameworks, IPA specifies a less flexible approach, a wholesale methodology accompanied by theoretical principles, study designs, data collection and analysis procedures (Braun & Clarke, 2013). Using TA is said to allow for exploration of more patterned meaning across the dataset.

IPA also seeks a homogenous sample to ensure the study remains relevant and personally significant to the respondents, and ensures researchers capture detail on a specific group of individuals with experience of a particular phenomenon (Noon, 2018). Whilst, the majority of Black people in the UK may trace their ancestry to Caribbean or African countries, race differs from ethnicity which involves socio-cultural factors such as shared histories, customs and values (Goulbourne, 2006). The heterogenous nature of the participants being recruited for this study therefore contradict the IPA requirement of a small, homogeneous sample group (Larkin et al., 2019).

2.9 Ethical considerations

Ethical issues pertaining to consent, and wellbeing of participants were considered in the planning and implementation of this study as evidenced in the ethics application (appendix J). The study was granted ethical approval from the University of the West of England faculty of health and applied sciences research ethics committee in July 2020 (appendix K).

2.10 Reflexivity as a researcher

As a young, Black African, cisgendered, heterosexual man and a sexual health practitioner, I approached this research with many perceptions of the social world, which I consider reflexively in this section.

Reflexivity, an essential principle of qualitative research, is described as the explicit acknowledgement of personal, political and epistemic stances that influence all aspects of the research, including design, process and interpretation of findings (Finlay, 2002). A vital part of the reflexive research process is understanding the self as a research tool (Watts, 2006). Unlike quantitative researchers, when analysing data, qualitative researchers become the analysis tool and are required to exercise judgement about coding, theming, decontextualising and recontextualising the data (Starks & Brown Trinidad, 2007). As researcher's behaviour affects participants' responses, therefore influencing direction of findings, it is recommended that qualitative researchers should practice reflexivity, acknowledging and disclosing their own selves in the research and seek to understand their influence on the research (Cohen et al., 2011).

The concept of insider/outsider status reflects the degree to which a researcher's lived experience, identities or status locates them either within or outside a group being

researched (Gair, 2012). Specifically, insider research refers to when a researcher shares an identity, language or experiential base with their study participants, thus making them a member of the population they are studying (Asselin, 2003; Kanuha, 2000). Being a Black heterosexual man from London, I shared a similar ethnicity, identity, and culture with my participants. I could not isolate myself from the phenomena I was researching and therefore approached the research as an 'insider' (Banks, 1998).

Some benefits have been described to insider research. The "insider" status can provide researchers with a certain amount of legitimacy and enable researchers more rapid and complete acceptance and openness by their participants which typically results in greater depth to collected data (Adler & Adler, 1987; Dwyer & Buckle, 2009).

My position as an "insider" produced some benefits. Whilst conducting interviews, I felt participants were at ease and responded openly to my questions, demonstrated by their use of cultural idioms and shared vernacular. This enabled me to explore personal and sensitive experiences in a way that a researcher of "outsider" status may not have been able to.

On the other hand, the "insider" status of a researcher has also been labelled with some limitations including the possibility that the interview becomes shaped by core aspects of the researcher's experiences, the analysis emphasises shared factors between the researcher and participants, and participants make assumptions of similarity and therefore fail to explain their experiences entirely (Dwyer & Buckle, 2009). This occasionally occurred, with some lines of questioning responded to with partial explanations followed by the words "you know what I mean". Whilst, occasionally, I knew implicitly what was being referred to, and I was pleased that participants felt they were provided with a safe and non-judgemental space to openly discuss their experiences, I remained cognisant of the need to separate my own experiences from those of my participants and sought detailed clarification when this occurred. My professional role as a sexual health practitioner helped me to sensitively seek clarification and elaboration from participants in instances where their responses were assumptive of my familiarity with their experiences.

Some techniques have been suggested to prevent the "insider" status of a researcher from detrimentally influencing the research process, maintaining objectivity, and establishing study credibility. A continual process of detailed self-reflection on the subjective research

process that acknowledges one's own personal biases and perspectives is said to alleviate the potential pitfalls that can occur with the researcher's insider membership (Asselin, 2003; Kanuha, 2000). Asselin (2003) goes on to advise that researchers should keep a record of their thoughts, feelings, and responses to interviews, re-read these periodically and discuss these with another experienced researcher.

As suggested, I kept a reflective research diary which detailed my thoughts and perceptions across the research process, including data collection, analysis and interpretation. I have included excerpts from my reflective diary (appendix L). I also received regular supervision from two experienced researchers. During supervision, I was provided with a safe space to reflect on the thoughts, feelings and assumptions I brought to the study and was regularly encouraged to write these reflections in my research diary to encourage transparency around the subjectivity of my interpretations.

Characteristics that construct our social identities include age, race, sexual orientation, class and gender (Collins, 2015). As identity cannot be isolated from research practice, reflecting on social identity and how it interacts with the research becomes an essential component of reflexivity (Day, 2012). Jacobson & Mustafa (2019) have proposed the use of their social identities map to aid reflexivity by enabling researchers to visualise how their social identities and positions impact the research process. The use of the social identities map is said to have the potential to reduce bias and promote an increased understanding of health phenomena through the lived experiences of participants (Jacobson & Mustafa, 2019). I completed two tiers of the social identities map (appendix M) to facilitate transparency of the identities, perceptions and opinions I brought to the study.

To increase the rigour and credibility in the findings of research, researchers are advised to use 'member checks', a process of checking data, interpretations, and conclusions with the study participants (Lincoln & Guba, 1985). As suggested, I attempted to engage study participants in this process. Three participants responded and validated consistency between the findings and their experiences.

As a sexual health practitioner, I am experienced at discussing sexual health and behaviours with individuals. As my role involves delivering interventions to try and increase protective sexual behaviours, I was required to remain conscious of my role as a researcher whilst

interviewing to prevent conflation with my day-to-day role as a sexual health practitioner, ensuring that I actively listened to the reality and experiences of participants without unconsciously delivering health interventions.

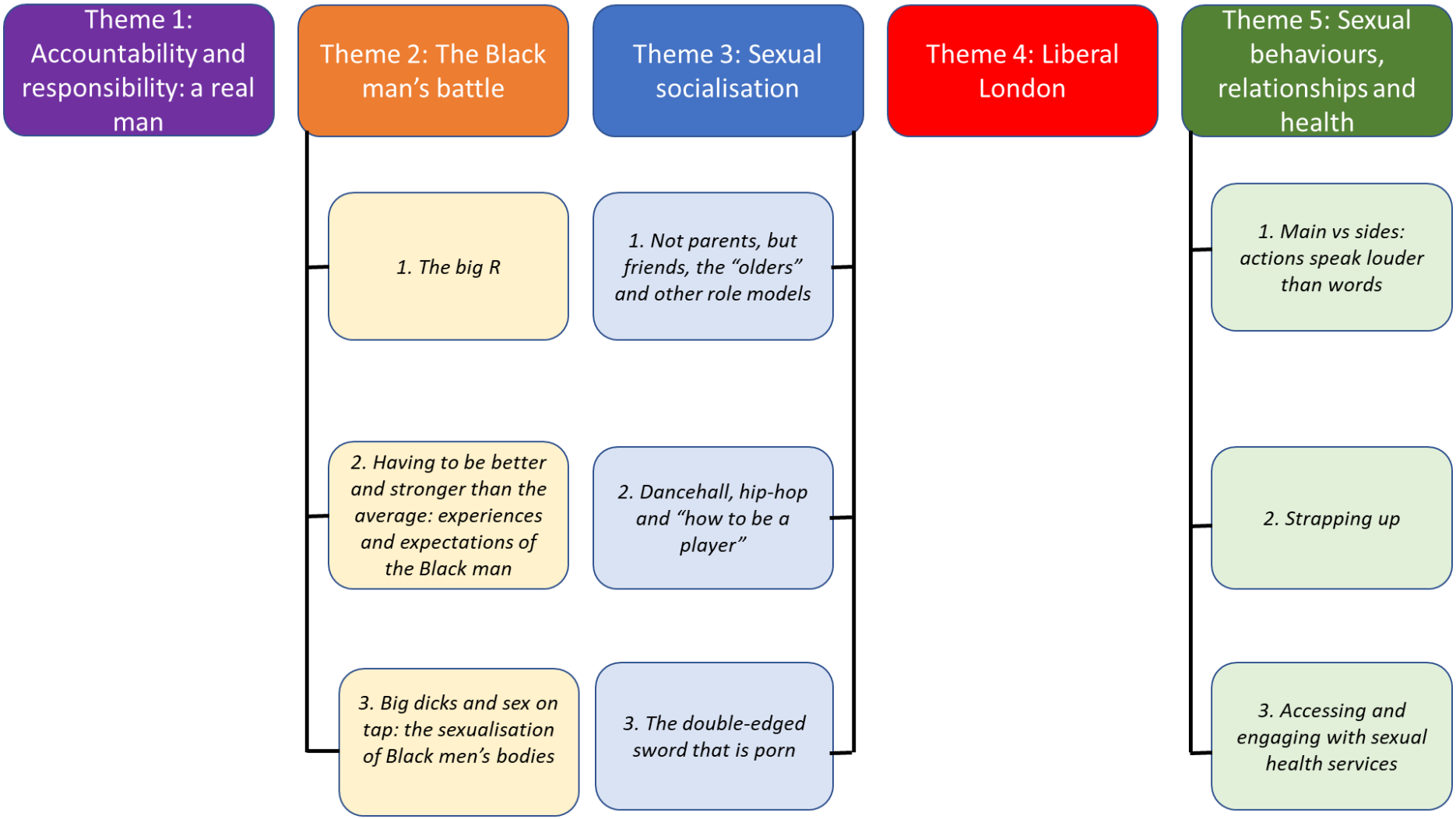
3.0 Results

This chapter will present the findings of the study in the form of a presentation of the themes and subthemes constructed through thematic analysis.

3.1 Themes

Five themes and nine subthemes were constructed as shown in figure 2. These are presented and accompanied with verbatim extracts from the anonymised interview transcripts to evidence discussions and provide context to the analysis.

Figure 1: Constructed themes and subthemes



3.1.1 Theme 1: Accountability and responsibility: a real man

This theme highlights the participants' perceptions of masculinity, including what they felt makes someone a real man and the way real men behave and conduct themselves.

Overall, selflessness epitomised the participants' descriptions of masculinity as perceptions largely centred around meeting the needs of others, particularly family members.

> *I think it [being a man] means there's something about the buck stopping here. Boys have got to understand that the buck stops with them, that they have this massive responsibility for taking care of people they're supposed to take care of.* (Marvin, 58)

> *You're taking more responsibility, you're taking more control here, and you're making sure that you're doing anything you can for the better of other people.* (Daniel, 24)

This responsibility extended to others, with several men emphasising the importance of being a positive influence on others. Perceptions of a real man were framed in relation to how others viewed them, and the extent to which others could approach them for help, advice or guidance.

> *I think it's just education. When I say 'education' I'm not physically talking about A-Level or O-Level or whatever. I think it's talking to people and telling people about your past experiences and showing them the right road.* (Dwayne, 46)

> *I think, for me, being a man is all about being there for people.* (Simon, 50)

Kamal elaborated and suggested that being a role model to others was a vital element of being a real man:

> *If you're gonna call yourself a real man then you have to be a person that people look up to.* (Kamal, 18)

Valued aspects of masculinity shared similarities with leadership characteristics but were framed in a paternalistic manner.

Martin framed his perception of a man as somebody who is viewed as honourable, wise and trusted within their family:

> *You're not a man until people, whether it's your friend or family, or someone that knows you, they can come to you for advice or help. It could be financial or it could be emotional, it could be whatever.* (Martin, 41)

The idea that masculinity is demonstrated through physicality or sexual behaviours, including the number of sexual partners was categorically rejected:

> ***Interviewer:*** *So how does being a real man reflect on sexual relationships?*
>
> ***Kamal:*** *I don't think it reflects at all because you can be a real man and have a lot of sex and you can be a real man and have no sex.*
>
> *No, I think having a lot of partners shows that you're still childish, you're not mature yet. You're still like a teenager; still want to have fun so you're not ready to be responsible.* (Ashley, 20)

One participant proceeded to critique ideas of hypermasculinity amongst Black men. Hypermasculinity was described as a fictitious label often assigned to Black men by people who have very little interaction with Black men and fail to see them as real people:

> *I've heard people talking about hypermasculinity but when I talk to real people, I don't see a lot of examples of it. Even as a youth worker, as somebody that worked in schools and taught at universities, I actually haven't seen a lot of examples of people with this hypermasculinity thing. I'm not sure that exists, particularly amongst, in a peculiar way, amongst Black people. I think it does for people who see us as cartoon characters, but when you meet real people, you don't see it.* (Marvin, 58)

In summary, this theme captured the meaning assigned to manhood and masculinity by participants. Ultimately, the meaning attributed to masculinity was largely centred around their responsibility to those close to them, particularly family. This meant that a man's presence in the lives of family and loved ones should be accompanied by feelings of positivity, comfort and safety.

Generally, there was no recognition of manliness as being measured by physical, financial or sexual attributes. There was a contradiction between the hypermasculine manner that Black men have been suggested to perceive as ideal, and how the Black men in this study described their perceptions of masculinity. Positive meanings were assigned to masculinity

with participants largely expressing their perception of masculinity and manhood as measured by the positive impact of their presence and actions on the lives of their families, loved ones or those depending on them. Whilst perceptions of masculinity were reflective of leadership standards, descriptions noticeably lacked factors relating to emotional intimacy.

A potential reason for the discussed similarities between leadership ideals and definitions of masculinity could be the resilience required to personally manage, and support family and loved ones to manage the unique experiences of being racially minoritised. The next theme will explore the participants experiences of living as Black men and meanings attached to this.

3.1.2 Theme 2: The Black man's battle

This theme captured the day-to-day experiences of living as a Black man across different aspects of life and highlights the meaning participants assign to being a Black man. Three subthemes were constructed: 1) the big R; 2) having to be better and stronger than the average: experiences and expectations of the Black man; and 3) big dicks and sex on tap: the sexualisation of Black men's bodies.

3.1.2.1 Subtheme 1: The big R

This subtheme captured participants' experiences of racism and marginalisation, and the impact of this on sexual behaviours, expectations and engagement with sexual health services.

Participants overwhelmingly described their experiences of racism as perpetrated by institutions rather than individuals. Personal experiences of racism reported by participants in this study shifted from individualised and explicit to institutionalised covert racism. This was vital as whilst those perpetrating explicit racism could be avoided, participants were voluntarily and involuntarily required to engage with institutions that perpetrated racism towards them:

> *We're still getting arrested at massive rates, we're still getting harassed on the streets by the Police. The education system is still failing us. It's just they're not calling us n****rs loudly anymore. So the change in behaviour hasn't created a change in outcome. I remember saying to my mum that the maths teacher was*

racist. My mum looked at me and said, "but you still have to learn maths from him". (Marvin, 58)

Specifically, the Police were identified as an institution that engaged participants in racially motivated interactions:

I've been stopped by police. I like going for walks. It helps with my wellbeing. I remember when I was living at my mum's and going for a walk. These undercover detectives came out of nowhere and were like "stop, there have been reports of a burglary and we need to search you". They just searched me and there was no valid reason. It was just that I "fit the description" as always. (Jay-Jay, 37)

The racially motivated interactions included adultification (Davis & Marsh, 2020) as a boy as discussed by Daniel:

You get treated like a level up. The age group up that you are and you see things earlier and for what they really are. I was with my dad one time at the train station. I was probably 8 years old at the time. My dad was a bus driver and had a pass to go through on TFL. He's gone through, not the gates, the barriers where the guy normally opens. My dad has walked through and shown his badge. As I'm walking through I have been pulled aside by 2 police officers. I'm 8 years old. My dad has just gone. Two police officers now are questioning me as if I'm a teenager. Obviously I've been 6 ft 3 since I was 15 so you can imagine the height, and then I'm Black. (Daniel, 24)

Participants spoke of various ways their experiences of racism influenced their lives including their engagement with health services and personal relationships.

Experiences of racism had a significant influence on the participants' dating behaviours. Settling down and starting a family with someone within the Black community was seen as a protective factor to prevent experiences of racism within the family as expressed by Daniel:

Daniel: *Once Black men get serious, and this is just me anyway, I know we're going to get married to a Black woman at the end of the day. I think in terms of dating and relationships, it's difficult because you're always thinking about their parents, and what their parents are gonna think, especially when dating outside of race. As a*

Black man anyway, you already know when you're about to get some nonsense coming your way.

Interviewer: *So would you say that's a big factor in you choosing to marry a Black woman? To prevent that experience of racism or microaggressions?*

Daniel: *Yeah, I would say part of it. My main reason would be for my kid. I want my kid to be understood. And I wouldn't want my kid to have to try and explain something to someone that's never gonna understand because they've never walked it. I could have a conversation with 10 White people and 10 Black people. I know it's gonna be easier to explain to the 10 Black people than to the 10 White people what happened to me that day, or what happened when the police stopped me. I don't have to paint the entire picture and then get "but why did you do this?" and explain myself.*

Institutional racism existent across various institutions was replicated in healthcare settings and consequently sexual health services. This was manifested through clinical advice underpinned by racist stereotypes regarding Black male sexuality as discussed by Ryan:

The first time I had sex properly was with a White girl. At the time, she went to a sexual health centre and she relayed that the sexual health nurse said she needs to get checked more regularly because she is having sex with Black men. (Ryan, 34)

However, rather than affecting how participants accessed sexual health services, racially underpinned stereotypes upheld by some staff in sexual health services had an impact on the treatment they received once engaged, and presented a need for Black men to reflect on how they are perceived in society and develop strategies to disregard labels bestowed on them:

I don't think it has an impact on how I've engaged with them, I think it has an impact on how they engage with me. Certainly, I think there is some kind of conversations that Black men need to have as they're growing. How do you rebuff all of what is thrown at you, as a Black man in terms of sex and sexuality, in terms of the way that other people impose ideas about you on you. (Marvin, 58)

Ultimately, in this study, institutional racism personally experienced or witnessed increased mistrust in health services which can result in avoidance until necessary as discussed by Anton:

> *I don't even go to doctors because it's a bag of shit, a mess. Unless I've got an infection. Not a sexual one, just an infection that you might need antibiotics for. Any sort of normal symptoms, I nurse myself back to health because I feel like if you go there, they just start telling you about different things. You might not even be diabetic but because it's seen to be whatever, they just start. I've seen it happen to many people. My trust for that is weird. How you're treated in the world, racism and stuff, you can't help but see that people might do the same to you*. (Anton, 29)

This subtheme has highlighted participants' experiences of racism and the complex and nuanced way that these experiences have influenced various aspects of their lives. Often, racism experienced by institutions were underpinned by widely accepted negative stereotypes regarding Black men.

The shift from experiencing explicit racism from individuals to institutionalised racism from institutions that participants had to engage with created an acceptance that there are attributes Black men must possess to be able to live in an unequal society.

3.1.2.2 Subtheme 2: Having to be better and stronger than the average: experiences of the Black man

Within this subtheme, several participants provided accounts of the unique barriers they have experienced and navigated because of their racialised male status, and how strength and resilience have become synonymous with Black masculinity and expected of Black men by themselves and others.

Some participants expressed feeling that Black men are constantly required to exert extra effort compared to others:

> *Being discriminated, always knowing there's going to be someone ahead of you. There's always going to be that White man ahead of you, so you've always got to work that extra hard.* (Ashley, 20)

> *You've always got to put in an extra 10% more than the other person. You've always got to do something with 100% or 110%. We aren't privileged. We haven't got an advantage in this country. We've got to fight for our place*. (Ryan, 34)

Martin elaborated by introducing the idea that Black men are required to demonstrate resilience on a day-to-day basis:

> *As a Black British man, even at work, I've always known I've got to be twice as better as this man, as a White man. As a Black man, the sky is the limit, but I know there's going to be hurdles along the way. There are no cry-babies over here, you've got to get on with it. Got to move on.* (Martin, 41)

Several participants attributed strength to what they believe it means to be a Black man. However, strength in this context was not referred to as a physical attribute, rather a mental one, and something required to survive in an unequal society:

> ***Interviewer:*** *What does being a Black man mean?*
>
> *It means to me, you've got to be strong. You've got to be stronger than the average because you've got to remember, this is not our country. And deep down, no matter what they say or do, they don't want us in their country. You've got to do better than the average and stand out to survive*. (Dwayne, 46)
>
> *Strong. Powerful. Being a Black man is about confidence. You've got to stand tall and hold your own. We've all got a weak side, but unfortunately we get pulled down quicker if we show vulnerability. We will get pulled down twice as quick.* (Simon, 50)

Some participants described a protective role as part of what it means to be a Black man:

> *As a Black male, we're kinda deemed to be like an alpha. Whether it's true or not, I don't know, but I think we're a support system. We're deemed to be quite strong so I feel it's just protecting, looking after your family.* (Anton, 29)

For Marvin, the need for strength, leadership and protection of others came directly from experiences of racism:

> *There's a certain amount of protection that has to go on if you're a Black man because you have to protect your family from the thing called racism. So, to be a Black man means you have this additional responsibility*. (Marvin, 58).

This subtheme discussed participant's experiences of living as Black men and what it means to be a Black man. Experiences highlighted that living as a Black man in an unequal society consequently requires Black men to exert more efforts than their counterparts whilst demonstrating resilience and strength. The use of battlefield-style language like *"fight, strong, powerful, survive"* implied that participants viewed their day-to-day existence in an unequal society as a battle they must navigate.

The expectations placed on Black men often went beyond professional, family and community contexts, and were echoed within expectations of sexual roles.

3.1.2.3 Subtheme 3: Big dicks and sex on tap: the sexualisation of Black men's bodies

This subtheme presents participants' experiences of racially motivated sexual stereotypes and expectations, and the potential impact of these on psychological and sexual wellbeing.

At a basic level, racially motivated sexual stereotypes created expectations on Black male genitalia:

> *In my opinion, in terms of sex, everyone expects you to have a long dick because you're Black, and then even more so because you're tall and Black. There's comments you get just based on that.* (Daniel, 24)

Exposure to sexual stereotypes often occurred from a young age and extended beyond size of anatomy to expectations on sexual performance and frequency of sexual activity:

> *I was definitely aware of the idea that Black men were supposed to be good at sex. I definitely knew that Black men were good at sex, White men were shit at sex, and that meant I had to be good at sex, didn't it. We are supposed to be able to fuck good, and lots and often. I definitely knew that Black men had big cocks and White men had little cocks and that meant I had to have a big cock didn't it.* (Marvin, 58)

This was experienced by some as an exaggeration of the normal adolescent feelings of inexperience. Martin felt the expectations placed on Black men regarding how sexually active they should be resulted in pathologising those who failed to achieve these:

> *If you're a man that hasn't had that much, or has no experience of being with a woman, there's something wrong with you. There's something wrong with you, yeah.* (Martin, 41)

The sexualisation of Black male bodies extended to being fetishized by White women:

> *I suppose one of the things I noticed as a young person was how interested White people were in me sexually. Particularly older White women. I don't know if that was something about me or about all kinds, but there was definitely a kind of energy from White women who were old enough to know better. I can name four boys in my year who were shagging White teachers at school and that, I know was a fact. That was part of how they saw their whiteness, the teachers, but also part of how they saw our blackness. And even at the time, I knew it had something to do with that.* (Marvin, 58)

> *My personal experience growing up being a Black man, a tall Black man and athletic, you get a lot of strange things that girls say to you about your chocolateness, and your blackness. What they want you to do to them. Then they might throw in the n***er here and there by accident. It's like, a lot of White girls just wanna try a Black guy. And Black guys just go along with it like "fine, yh try me".* (Daniel, 24)

There was recognition of the way Black male bodies are depicted in pornography which contributed to the fetishization of Black men:

> *I feel like Black men are, because of all the porn that's out there, the ebony porn, depicts us to have large parts down there, it promotes or intrigues females from other cultures and they feel like they need to explore. So I do think sometimes you're looked at as a bit of an exotic animal*. (Anton, 29)

Harm can occur because of a gap between expectations underpinned by racialised pornography and reality:

> *There are some Black males that are not gifted as how they're perceived in the ebony and stuff. That might have a mental scar on them and they just hide in a cage because they're not living up to expectations of what the world says you should be*. (Anton, 29)

The multidimensional impact of racially motivated sexual stereotypes cut across many areas of participants lives with potential for physical and psychological harm. Marvin felt that sexual stereotypes potentially influenced the explicit racism experienced by Black men:

> *There's something about the Black stud that they kind of imposed on us. I suppose that gave them permission to treat us in certain ways, to see us in certain ways. Also, it meant White men had yet another reason to be scared of us. Because part of that myth is "these people are better than you and you can do nothing about it. They got bigger cocks and they can fuck better than you" (LAUGHS). That's what's being whispered into the White man's ears. No wonder the man wants to call us n***ers (LAUGHS). And their women started behaving as if it was true because there was definitely big groups of White women who had to have Black men.* (Marvin, 58)

Some felt that these sexual stereotypes directly influenced sexual behaviours through coercion into meeting expectations which subsequently resulted in engagement in unwanted sexual encounters:

> *I knew it created some kind of pressure on me to be this thing that Black men was supposed to be. And I think the other side is THNKING that you want to have sex more than you want. There's a pressure to want to have sex. I gave into the pressure, but I don't think I particularly wanted to have sex all of the time. I don't think it was so much on my head.* (Marvin, 58)

There was recognition of how harm can occur through the negative impact on health seeking behaviours. The fear of being judged by sexual health clinicians with preconceived ideas about the sexual activities or anatomy of Black men was described by participants who feared being stereotyped for both what they should be doing or being judged for what they were doing:

> *I know they have a triage form and they need to ask certain things. I guess when I'm disclosing that in the past 3 months, I have had X amount of partners, I always feel in their head they're kind of judging me.* (Jay-Jay, 37)

> *I can't speak for all of them but I think, let's say a Black male was going through erection problems or whatever, I don't think they'd feel comfortable saying that*

> *because of porn and how Black males are meant to have tings that are as big as horses. It's a bit mad, the connotations of life, or how you're portrayed which obviously stop you from doing it. You may feel "naah, I can't". Then if you say it, or someone says it out loud, you feel you're not living up to expectations of you. Even if it's fake anyways, a lot of people live their life in a bubble. I feel we find it hard to explain our problems and I don't feel like we feel comfortable explaining them*. (Anton, 29)

> *I always thought when I see the nurse they're gonna be thinking the reason I'm here is because I've been having lots of unprotected sex and I'm not really a responsible adult and stuff like that.* (Ryan, 34)

Ryan elaborated on how stereotypes affected how he felt about himself as a Black man:

> *As a Black man, growing up hearing stuff, how people portray or think of you, it has a negative impact and negative stigma. You feel low of yourself because what are they trying to say? That you're some raging beast that don't have control and go around having unprotected sex here, there and everywhere. It just made you feel very low about yourself.* (Ryan, 34)

This subtheme has highlighted the sexual expectations placed on Black men as experienced by participants. Participants expressed that expectations were underpinned by racist stereotypes concerning Black male sexuality and impacted their perceptions of how they should behave. Consequently, expectations mirrored how participants were sexualised and subsequently treated, which in turn impacted sexual development and created barriers to accessing services.

Broadly, this theme presented participants' experience of living as Black men, including their experiences of racism, expectations placed on Black men and characteristics they must demonstrate to survive the battle that is living as a Black man.

Ultimately, being a Black man was described as a unique experience that required participants to demonstrate strength and resilience to cope with, and protect family and loved ones from experiences of racism. Exposure to racially underpinned stereotypes were said to negatively affect engagement with, and treatment received by institutions. These

stereotypes extended to sexual encounters and encouraged sexualisation of Black male bodies including perceptions on sexual ability and behaviour. Consequently, harm was experienced in the form of low self-perception, coercive sexual encounters, and barriers to accessing services through fear of being judged.

3.1.3 Theme 3: Sexual socialisation

This theme will present participants' experiences of engaging in the sexual socialisation process and how this process was uniquely shaped by them being Black males. Several sources of sexual socialisation and education were acknowledged alongside the varying impact of these sources. Whilst some of these sources (e.g. pornography) are generally regarded as negative sources of information, participants identified a positive element to their use.

3.1.3.1 Subtheme 1: Not parents, but friends, the "olders" and other role models

When discussing sexual socialisation, participants reflected on their experiences as Black boys and acknowledged the primary role of their peers, older males in their local community (the "olders") and older family members including brothers and cousins as sexual educators and role models.

Participants generally expressed receiving little to no formal RSE in school:

> ***Interviewer:*** *Did you learn much from teachers about sex and relationships?*
>
> *Nothing, absolutely zero. I didn't have sex education. I think we may have had someone come in and talk to us about it and the school was trying to make it compulsory, but they didn't, especially for my year.* (Ryan, 34)
>
> *We didn't have any sex ed in school, 100% we didn't. The closest thing we had to sex ed was students trying to put porn on their teacher's computer, on the big screen and then obviously get in trouble by that.* (Martin, 41)

Here, Ashley discussed the biological nature of RSE he received at school and the irrelevance of it:

> ***Interviewer:*** *At school did you have sex education?*
>
> ***Ashley:*** *Yeah, yeah.*

Interviewer: *What was that like?*

Ashley: *You know what, I can't remember it. What year did we have it? Probably in like year 9 I think. I can't remember, they were just telling us about body parts and stuff so yeah, I can't really remember it.*

Interviewer: *Do you think it was useful for you?*

Ashley: *No, I think it was pointless man. It was just more of the science side of it. It actually wasn't sex education.*

Participants also highlighted that they had very little dialogue with their parents about sex and relationships. This was often due to a generational divide where sex is viewed as a taboo subject within certain Black communities. Participants discussed their parents perceiving sex as something that caused harm and therefore wanting to protect them by encouraging minimal sexual practices or avoiding dialogue altogether:

> *With Nigerian culture, talking about sex and things like mental health, they're very taboo subjects. It's like you'll turn 16 and your parents won't talk to you about sex, but when you hit 25 they'll be like "when are you going to make me a grandparent?". So you went from 0-16 not talking about sex to wanting a grandchild. You can't win.* (Jay-Jay, 37)

> *My mum wasn't going to explain it to me. As I got older my dad has expressed he would have been calm with everything like that. All I had to do was explain it to him. I just didn't so he just didn't say anything. It was one of those ones*. (Daniel, 24)

> *In terms of your parents, I feel like obviously they want the best for you they made a decision to settle down with someone so their outfit will be "you shouldn't do this because the more girls you have the more risk out there". They're thinking about the sexual implications. Whether you might have a baby or something that's life changing and can't take it back. I feel like it will be a stark contrast to peers, older mentors, role models. Sort of a taboo topic*. (Anton, 29)

Older siblings were acknowledged as being supportive and open to discussions whilst parents were silent or disapproving.

Ashley felt that whilst his parents had their own experience of sex, the generational divide between him and his parents meant that he generally had more meaningful conversations about sex and relationships with his older brother:

> *Parents are just so overprotective so don't really let you reason. When I speak to my brother, he's been there, done that, so he knows. Even though, obviously my parents have been there, he's a couple of years older than me so he understands where I'm coming from*. (Ashley, 20)

Daniel suggested that the generational divide in perceptions around sex and relationships were also present between his sister and mother. In discussing how each would react to awareness that Daniel had multiple sexual partners:

> *My mum, she'd be disgusted. Horrified. Mortified. She'd be like "wow, that's not who I brought up". My older sister is the only person I would disclose any of this to if I wanted to disclose to a sibling. I think my sister would just be like "it is what it is.* (Daniel, 24)

Advances in communication technology contributed to the generational divide between participants and their parents and this was evident through the stark differences in the way relationships start:

> *Those days, it was stricter in terms of what you can do. And more serious. So if you liked a girl, you didn't have mobile phones. You'd literally have to call the parent's house, have to be respectful and call her a few times. Then you might be able to date her but the parents are involved in that situation. Then you had to make up your mind about whether you wanted to marry her, so things were different then. Now, we have personal phones and social media to connect with people. It has made the world a lot smaller where you're cutting out the middle man of protection, your parents. Your parents have lived it so it's their job or duty to tell you what's what. Instead of saying sex is good, they'll probably try and protect you from it and tell you to focus on your books*. (Anton, 29)

The lack of, or irrelevance of RSE alongside a generational divide that ruled out parents as a source of information meant that in this group, early education about sex and relationships

was obtained informally at secondary school age, often through conversations with, or observations of peers, older siblings or other role models including older males in the local community:

> *On the street! When I think about it, nobody educated me. We had a set of friends that lived in the estate and they were they were like two, three years older than us. I looked up to them man. I never wanted to be like anyone but I did look at certain man and think "yh them man are doing big tings".* (Simon, 50)

> *Through friends. It wasn't through school SRE or nothing like that. It was through friends. I'll never forget, I was in year 7 or 8 and one of my friends was like "did you make her cum?" and I was like "as in come here?". I didn't understand the concept of orgasmic climax. They all laughed at me. I felt like such an idiot.* (Jay-Jay, 37)

Access to older and more experienced siblings or cousins resulted in exposure to sexual content from a very young age for some participants:

> ***Kamal:*** *All my cousins are older than me. I'm one of the youngest. They're having their grown-up conversations and I'm just there so I hear it, become inquisitive and just ask questions.*
>
> ***Interviewer:*** *And when you asked questions, were they receptive? Did they bring you into the conversation or tell you not to worry as you're still young?*
>
> ***Kamal:*** *Nah, they welcomed me in. Obviously, they weren't going into depth and the detail that I know now, but if I asked a question it would be answered. But, I rarely asked questions. I'd just stay there and just listen. When you're young you don't wanna go and say the wrong thing and everyone thinks "aahh what's he talking about? (LAUGHS)".*

Observed interactions between "the olders" and girls served as informal lessons on characteristics and behaviours participants would need to demonstrate when attempting to pursue sexual and intimate relationships themselves.

> *I would see the way they (the olders) would chat to the girls and then the way the girls would run to them. And how they would move to impress the girls*. (Ashley, 20)

> *I remember being on the bus to school and the olders were sitting at the back. Girls would get on and the olders… The way they would talk to them was just very up front. The thing I did idolise is their brashness, their ability to just go for it. I was timid and always used to think "what if she shuts me down, blasts me or laughs at me" but I guess it comes with experience. Those guys had obviously been chatting up girls far longer than me so they had that in them*. (Jay-Jay, 37).

In this subtheme, the primary role of friends, older males within the community and older family members on the sexual socialisation and education of participants was highlighted. The stigmatised nature of sex within certain Black communities made it difficult for participants to engage their parents in dialogue about sex and relationships. This resulted in peers often being primary sources of sexual education. This primary role was more important as parents were not a source of information but also represented a contrast in perceptions concerning sex and relationships, and stark differences in behavioural practices.

There was a lack of formal RSE received by participants, and where this was received, the content was often focussed on biology, rendering it irrelevant. This meant that whilst initial RSE obtained from peers was more relevant to participants, it was also likely to be susceptible to inaccuracy.

3.1.3.2 Subtheme 2: Dancehall, hip-hop and "how to be a player"

This subtheme encompasses the role of entertainment content, including music and films, in the sexual socialisation and education of participants.

As discussed in the introduction chapter, dancehall and hip-hop are two musical genres that are popular within Black communities (Peterson et al., 2007; Primack et al., 2008). Participants acknowledged the influential role of these musical genres on their sexual attitudes, perceptions, and behaviours, particularly during adolescence.

The explicit nature of lyrics and content in hip-hop music was said to provide a hypersexualised introduction to women's bodies and often at a young age, albeit in an informal manner with informal terms used to reference anatomy:

> *The songs we were growing up with, rap songs and stuff like that. You used to hear rap lyrics talking about women with booties and stuff like that. That's when we*

> *started to realise other components on women. Sexual kind of stuff. And especially Eminem. I think Eminem was a big factor. He was so big. You listen to some of his lyrics now and think, "Jesus, did I really listen to this at eight?"* (Ryan, 34)

The influence that music and films had on perceptions of how to behave was discussed by several participants.

> *I feel because we take our ideologies from rap, our perception of what we should do, what's acceptable, how we treat people, sometimes isn't correct in my opinion. Once you move into rap music and it started seeing females like items, calling them female dog names and that, it sort of was a re-shift. If you kinda like that and you don't have a strong mind, you can easily fall into that way of thinking*. (Anton, 29)

> *You can stem it down from the Black community. There was loads of Black films back in the day, like Baby Boy, or How to Be a Player. Those kind of films that came out in the early 2000s portrayed this [having multiple partners] as the right thing to do. It's like "ah yeah, this is how Black men should be, this is the epitome of what we're supposed to be". I feel like we as a collective [have] taken on those influences and that's the music we listen to. That's the films we're watching. We weren't going to watch Romeo and Juliet. We weren't watching Titanic with all the lovey-dovey stuff. We were watching How to Be a Player. We were watching Friday. We were watching all those films portraying that kind of image of a Black man.* (Ryan, 34)

The images portrayed in hip-hop and dancehall music videos, and films created a particular image of successful Black men and ideas regarding their behaviour. Some participants suggested they may have subconsciously adopted this behaviour to demonstrate success amongst peers during adolescence:

> *A lot of people don't think of it, but it's a subconscious behaviour because you're feeding in all this information from films, rap lyrics and stuff like that, then you're doing it in real life. When you study why you're doing it, you're doing it for the points of, "I'm portrayed as this person that everyone is seeing and I'm more like him than you. I'm on the higher peak of the mountain than you. You're down there and I know you're tryna get up here, but I'm already here at the top of the mountain*. (Ryan, 34).

Furthermore, participants indicated that the depiction of the successful Black man is also embraced by some women as the status associated with these depictions in music and films attracted women in real life and provided further positive reinforcement:

> *It fully gasses people up. Perception vs reality. Look at the whole "relationship goals". A lot of these rappers with certain cars they're pushing, certain clothes, the girl they have on their arms. Guys feel a lot of pressure [to replicate].* (Jay-Jay, 37)

> *Music culture is a part of it. Media is a part of it. Most scandals that we see or read about on media, about these rappers doing this and that. You always see the girls in the VIP section [in bars and nightclubs] with the guys popping bottles. They've got the Rollies [Rolex watches] on their hands and obviously they're smashing. It's like an accomplishment to have all these pretty women around you. Women are going to gravitate to you more. I've done music, I've been around that kind of life. Women will gravitate towards men who have more*. (Martin, 41)

Dancehall music was identified by participants as having a strong influence on the types of sexual behaviours Black men engage in and particularly stigmatised Black men performing oral sex on women:

> *Music plays a big part. We listen to a lot of dancehall music. Them man are the first to say "man don't do them tings there [perform oral sex]". We have adopted the Caribbean mentality here in England because in America, them man will tell you straight [they perform oral sex]. I believe that we're such a Caribbean culture outside the Caribbean. Americans don't care about it. White man straight don't care. That leaves us. Can't speak for the Asian man there. But I believe it's down to the music culture. It's promoted amongst Black people through our music.* (Simon, 50)

Anton was keen to suggest that the influence of media content on sexual behaviours and partnerships was stronger during youth and adolescence, but subsided as one aged and matured:

> *Obviously it's glorified in my music in my culture to have multiple partners. It's seen as you're the man. But as you grow up you realise that you can only build with one person so it changes your ideology*. (Anton, 29)

Whilst consuming and enjoying musical content that was promoting multiple sexual partners, observing his mother and father's relationship as a contrast to what was being promoted helped Anton to distinguish between reality and entertainment:

> *Even though I was listening to dancehall music that was coming out, I was very fortunate to have a mum and dad that lived under the same roof, married, done the "right thing". I don't know if it is the "right thing" but at the time I had that there so I couldn't say "my dad's not around so I'm doing this". I could see that life was entertainment because I could see a stark contrast to what was my reality. Other people that might have grown up in a single parent home, or different situations may look at that music and draw a bit more relation or guidance towards it.* (Anton, 29)

This subtheme has highlighted the influence of music and film content on the sexual socialisation and education of participants. It can be argued that these influences are greater on young Black men as they often occur in the form of music and films that are popular within Black communities and are often accessed from a very young age. Maturity that was acquired during ageing resulted in the dismissal of the messages promoted in explicit media content and enabled acknowledgement of this content as purely for entertainment purposes rather than a representation of success.

3.1.3.3 Subtheme 3: The double-edged sword that is porn

This subtheme will highlight participants' experiences of engaging with pornographic content including the purposes of accessing pornography and perceptions on the usefulness and limitations of pornography.

Most participants suggested they had experience of engaging with pornography. Initial engagement with pornographic content usually occurred at a young age:

> *For me, I saw that at a young age. The generation before me, it was probably magazines. For me, I found one of them cheeky DVD's and it was around the time that DVD players were coming out. My brother just happened to have one stash in his chest of drawers so one day I stumbled across that and that's where it kicked off*. (Anton, 29)

> *Sometimes I'd go into my IT lesson and there'd be porno on the screen because the teacher has left the computer on, one of the boys thinks it's funny to go on a porno site and put in something like "girl gets doggy", puts the volume on max. You can hear it from outside the classroom. You go in the class and it's someone's cheeks getting clapped! (LAUGHS)* (Ryan, 34)
>
> *I would say I discovered porn when I was like 10. Porn was important from the age of 10 probably*. (Daniel, 24)

There were both positive and negative factors associated with accessing pornographic content. For some, viewing pornography was the first time they saw a woman naked, and despite the unrealistic depictions of bodies often seen in pornography, this helped them to acknowledge variations in the shapes, sizes and appearances of women's bodies:

> *Obviously you put on porn and watch like certain attributes, certain differences about a woman's body. "Okay, not all breasts are the same, not all vaginas look the same, not all bums look the same". You see different shapes. Back then I had never seen how a woman's body looked naked so porn was an introduction to how a woman's body looks naked for me.* (Martin, 41)

Pornography was also identified as a useful educational source before sexual debut. The nature of formal RSE was often limited to STI and pregnancy prevention strategies, meaning nobody had taught them how to have sex or what to do during a sexual encounter. This is where pornography became useful:

> *When you're watching pornography, you're learning stuff as well. I learned different positions, how to… [perform] oral as well, because obviously back then there was a stigma around it and no one was doing it. Watching porn, it allowed me to learn oral, different positions and stuff like that.* (Ryan, 34)

However, for other participants, engaging with racialised pornographic content resulted in the development of insecurities regarding sexual performance and size of genitals. For Jay-Jay, this resulted in him perceiving orgasm as an indicator of a woman's satisfaction with the encounter and constantly sought validation from sexual partners regarding his performance:

> *You look at some pornstars, I always used to compare my manhood to theirs. I had this weird thing of like "am I giving the girl as much pleasure as much as these pornstars are?" I had this thing in my early sexual encounters, I always used to ask my partners "did you cum, did you cum?"* (Jay-Jay, 37)

For Anton, it was the combination of racialised pornography and conversations with peers that resulted in insecurities concerning his sexual performance.

> *So you're watching porn or you're hearing stories about how I lasted 12 hours and (LAUGHS) all night and whatever (LAUGHS). You're getting told that and thinking "rah I'm slacking init".* (Anton, 29)

Ryan reflected on his engagement with racialised pornography and concluded that whilst there were positives associated with viewing pornography whilst young, ultimately it had a detrimental impact on his sexual wellbeing as an adult and has the potential to affect his sexual relationships:

> *One of the negative impacts would be it takes a long time for me to orgasm or climax. You're going to school and the girls would say, "He lasted three minutes," and then you're thinking you never want to be that person. It has to last an hour or an hour and a half for me to climax which is a very long time and a lot of women don't have patience with that. I think that all stems from watching pornography*. (Ryan, 34)

This subtheme has discussed the role of pornography in the sexual socialisation process. Participants expressed both positive and negative factors associated with their engagement with pornographic content, particularly from a young age. Some participants expressed developing insecurities having consumed racialised pornography.

Broadly, this theme has discussed participants' sexual socialisation experiences and highlighted some sources participants identified as key in their acquisition of sexual knowledge, development of sexual attitudes and engagement in sexual behaviours.

3.1.4 Theme 4: Liberal London

This theme will discuss participants experiences of London, their perceptions of how growing up and living in London influenced their sexual attitudes and behaviours, and sexual norms that are promoted amongst Black men in London.

Participants expressed growing up and living in London impacted their sexual activity in various ways, including number of sexual partners, age of sexual debut, and demographics of sexual partners.

Growing up in London exposed participants to a peer culture promotive of early sexual debut. Below, Jay-Jay discusses how exposure to peer pressure from male peers promoted the early onset of sexual activity:

> *Erm, growing up, it was everyone striving to be the top dog. It was all about the latest creps you were wearing, how much girls you have been with, what girls you are beating [having sex with]. It was about how soon you lost your virginity, who is the strongest. All of that typical male bravado*. (Jay-Jay, 37)

Furthermore, several participants expressed growing up, as young Black men, within a culture where having multiple partners was the norm and was openly promoted:

> *In the Black group of young men, that culture is like "ay you man, guess what. Yh man went to link [meet] that ting [girl], and then gone to link that girl. I went to her school yesterday, but she knows dah-dah-dah [another girl], and I can't go and see her because she knows dah-dah-dah because she goes to that school"*. (Ryan, 34)

> *When we were younger, we generally didn't care. It was just more of a competition who could get the most girls*. (Ashley, 20)

Simon acknowledged experiencing this norm whilst growing up and suggested that it was a culture that was naturally accepted and adopted as opposed to a culture that one was officially introduced to:

> *Yh, the culture was definitely "gallis". Don't have one girl. That was the culture growing up. It's funny, no one told you about it. It was a culture that you feel that you're in.* (Simon, 50)

The purpose of having multiple sexual partners was associated with internal and external validation. Consequently, those who could demonstrate that they had multiple partners received positive recognition that enhanced their ego, status and reputation amongst peers:

> *I dunno what your life was like growing up, but people saw it as being cool if you had*

girls around you so a lot of people strived to be like that. (Anton, 29)

Interestingly, the visual appearance of having more than one partner mattered more, suggesting that public perception about the number of partners one had was more valuable towards recognition and status than actual sexual encounters with partners:

> *Yeah, but the funny thing is, people will see who's coming to see who. As long as you had one or two female friends coming to see you, you felt good. Like, you have to be seen with more than one girl. Not that you're sleeping with them, but people make assumptions*. (Simon, 50)

However, rather than being underpinned by race and ethnicity, there was a feeling that this culture was largely underpinned by youthfulness and peer pressure:

> *To tell the honest truth, I haven't thought about it in relation to me being Black and having sex and sexual relationships. At the end of the day, I just wanted to be like my friends. I never went through a thing of me being Black in the sense of it affecting sexual acts or sexual relationships. All I wanted to really do is follow my friends, to put it in a nutshell*. (Dwayne, 46)

Whilst there was little to no experience of living outside of London, many participants perceived that their sexual experiences would have differed had they not grown up or lived in London.

The geographical size of London was identified as a factor in engaging in concurrent sexual partnerships as sexual partners are less likely to encounter each other unlike in smaller regions:

> *Because you're living in London, how do I say? You can cast a wider net.* (Martin, 41).

Ryan expanded on this and suggested that his sexual experiences may have been different largely due to his race:

> *I don't think I would have been able to integrate that much with women outside of London because outside London, there's very few Black people. If White women were to have a relationship with you, it would probably be in secret because all their*

> *friends are having relationships with people that are White. They would probably not want to show you off in that way. That's just all my opinion though.* (Ryan, 34)

Several participants shared a perception that the women encountered in London were more sexually liberated thus making sexual encounters more likely than outside of London where they perceived women to be more sexually guarded:

> *Women now, they're definitely more sexually liberated. I mean, I've had women approach me for sex. I've been around a lot of countries, they're more subtle with it. London is the only place where I've had a woman say, "you know what, I want to fuck you," straight up*. (Martin, 41)

> *100%. Girls out of London are, I don't know how to explain it. I think because London is a vibrant place so they're [girls in London] just more outgoing I would say*. (Kamal, 18)

Perceptions of concurrent sexual partnerships changed as participants aged. Whilst there was status and recognition associated with having multiple partners as a young Black man, alongside a requirement to be seen with multiple partners, this became a behaviour largely unspoken of when older:

> *Now, I mean it's not something that you tell, like boasty-boasty in a way*. (Ryan, 34)

> *A player and that. I think as you get older, you don't really care, it's not really like a big issue.* (Ashley, 20)

> *It's not something that we can brag now at our age. Especially at my age now, it's not a bragging thing. There's no qualification in sleeping around. There's nothing boastful about it. You can't go out on the top of the mountain and shout, "I slept with 100 people!" Man or woman*. (Martin, 41)

This indicated a normalisation of concurrent sexual partnerships amongst some participants and a change to the purpose. Ryan supported this and attributed the change to getting older, establishing new friendships and a career. Furthermore, a similar culture was said to be present amongst non-Black young men also, but differences existed in how young men of different ethnicities vocalised their sexual activities, something which Black men adopted

later in life:

> *I used to mix with different groups when I was in school. When you speak to a Black guy, it's always talking about having multiple partners or talking to multiple girls. When you're talking to the white guys, they're doing the same thing, but they're not making it known. They're not boasting about it. It's all done in secret. I feel like the Black sexual culture between men, especially under 25, or should I say 20, it's all about ego boasting. It changes when you get older because you separate from certain people. You all get older, you all go into certain careers, you're not together anymore and your views start to change. But back then, it was cool to let everyone know that you're a bit of a scumbag! (LAUGHS).* (Ryan, 34)

Alongside a shift in perception, the reasons for embracing concurrent sexual partnerships also changed. For some participants, it was felt that concurrent sexual partnerships occurred as a result of them capitalising on opportunities they were confronted with rather than them actively seeking subsequent partners:

> *It wasn't a thing where I actively went out to look for another sexual partner to keep it 100. That sexual partner was before I even had the relationship so it was like rekindling what we had already. It's familiarity with someone that breeds that kind of moment*. (Ryan, 34)

> *Yh I was having sex with two different people, it was just a thing I was doing. It just happened. I wasn't thinking "I need to have more than one partner"*. (Kamal, 18)

> *I've never gone out to look for it. Situations just fall onto my lap and from there the experience is good. Deep down it's bullshit, but it is good. That's why I guess, speaking for myself, I indulged in it*. (Simon, 50)

For Simon, the variation in experiences with different women was something he valued and felt underpinned his concurrent partnerships rather than these encounters serving as an enhancement to his ego:

> *It wasn't an ego thing, nothing like that. I done it because I wanted to do it. It's like, everyone's different. Every woman, they're coming from a different way, let's be*

honest. Sex, communication. Yh, the communication and the sex is just totally different between everybody in my experience. (Simon, 50)

This theme has discussed how place, London in this case, influenced the sexual attitudes of participants through cultures and behaviours. There was an acknowledgement that growing up and living in London as a young person exposed participants to peer pressure that encouraged the early onset of sexual activity. Many participants suggested that their sexual experiences would have been different had they grown up or lived outside of London as they felt women they encountered in London were more sexually liberated and this served as an encouraging factor in their sexual encounters, further facilitated by the geographical size of London.

As young Black men, several participants were exposed to a culture where having multiple partners was promoted and expected of them. However, the need to demonstrate having multiple partners declined as participants aged, to the extent where it became inappropriate to boast about it. Despite this, where the behaviour was maintained, it was for various reasons including normalisation of behaviour, appreciation of the variation in sexual experiences and opportunistic sexual encounters.

3.1.5 Theme 5: Sexual behaviours, relationships, and health

This theme explores the participants experiences of engaging in sexual relationships and the meaning assigned to their sexual behaviours. Furthermore, this theme discusses participants' experiences of accessing sexual health services. Three subthemes were constructed: 1) main vs sides: actions speak lounder than words; 2) strapping up; and 3) accessing and engaging with sexual health services.

3.1.5.1 Subtheme 1: Main vs sides: actions speak louder than words.

This subtheme will discuss participants' categorisation of partners when engaging in concurrent sexual partnerships, variation in sexual behaviours with partners and meanings assigned to some sexual acts.

Several participants described categorising partners according to the nature of their relationship. Whilst labels assigned to partners varied, participants generally identified a main partner who they perceived to have the most promising relationship with, and with whom they would allocate more efforts towards:

So in my mind, I have wifey. This would be my main girl. The one I would devote the bulk of my time to, take on dates, it's not just about sex. We got a shared sense of working towards something, towards the future. Someone that's casual, a sidepiece, I'd define them as someone who knows what it is, there's no qualms about it, late night texts "are you free? Come over. (Jay-Jay, 37)

Obviously you'd have one that you're more inclined to, more of a connection to, so you may treat her better than the rest. Maybe she can sleep over whereas another one, "no, you've got to go home", that kind of thing. (Martin, 41)

Categorisation of partners reflected how participants behaved. Participants talked about engaging in condomless sex with main partners as a token of exclusivity, familiarity, and trust:

If I'm gonna have sex with someone I know, I'm not gonna use a condom. I make sure that she's in receipt of contraception, we have some level of history prior and now have a mutual trust that we have both checked, we're both healthy, and we're both with the idea of having unprotected sex. (Jay-Jay, 37)

You got a main person, then it's alright to bareback and explore. Then if you have other tings that it might only be sexual, or want that "good good", then you might be like "if it's just that then let me protect myself. (Anton, 29)

Participants generally identified a greater level of seriousness associated with condomless sex and used the action as a token of trust:

It's [condomless sex] for number one to feel like they are number one. They have that sense of feeling that they're number one. They feel more secure that you're doing that with them because you ain't going around doing that with everyone. Even if they had the slight inkling of you having multiple partners, they would know that only one of them is going to be getting it with that [condomless]. (Ryan, 34)

Other participants felt it was more than that and signalled exclusivity with a main partner:

You were deciding that you are regularly going to have sex together, and more importantly, that you weren't going to be having sex with anybody else. That was the agreement. Of course, if you stop using condoms in your relationship, it meant that

> *you weren't gonna be having sex somewhere else and exposing somebody else to danger*. (Marvin, 58)

> *You know what, she became like my partner. That's the only way I can put it. It's like she became my partner so everything was dropped. All protection dropped. She was on the pill. That's it really*. (Simon, 50)

However, this token of main or exclusive partner was more loosely applied by others. For Martin, the demonstration of exclusivity associated with condomless sex applied even when there was no official label assigned to the relationship:

> *It'll [condomless sex] make us exclusive in a way. Even though we don't have that title of 'girlfriend' or 'boyfriend,' it would make us exclusive so I wouldn't wear a condom.* (Martin, 41)

This subtheme has discussed how participants categorised their partners and the variation in condom use behaviour between different partners. Exclusivity, familiarity and trust were identified as prerequisites for condomless sex whilst the abandoning of condom use was used by some participants to demonstrate an increased perception of seriousness in their sexual relationships. However, the lack of consistency around the application of these principles in reality may increase risk of STI acquisition at an individual level.

3.1.5.2 Subtheme 2: Strapping up

This subtheme will discuss participants' perceptions of condom use and factors that motivate condom use.

Several participants disclosed negative experiences of using condoms which influenced the development of pessimistic perceptions and attitudes towards condoms.

Feelings of condoms interrupting sex and being awkward to use were expressed:

> *I mean, one of the big lies is that condoms don't interrupt sex. They are the most annoying fucking things to use (LAUGHS). They get in the way, they break, they roll the wrong way. They're just awkward*. (Marvin, 58)

> *I remember fumbling opening up the condom. I remember putting it on was awkward. I think at one-point it may have even came off whilst having sex. It was just very awkward.* (Jay-Jay, 37)

Furthermore, Jay-Jay discussed perceiving condoms as inconvenient, restrictive and having a negative impact on sexual excitement:

> *For me, I've always associated it as a inconvenience and vibe killer. When you're in the mood and then "ugh have you got condoms?" Then you have to go and find them. It makes me feel restricted when I use condoms, like a necessary evil. I don't feel liberated. I feel more free when I can have sex with someone that I don't have to rely on a condom*. (Jay-Jay, 37)

There was a perception that using condoms made sex feel artificial and reduced the level of intimacy experienced during sexual encounters:

> *It [using a condom] definitely feels different. A bit more artificial. Definitely doesn't feel intimate so to speak. The whole thing of sex, it can't be done on an artificial tip. Well it can be done but you're not getting the full benefit.* (Anton, 29)

Some participants perceived using condoms had a detrimental impact on their sexual performance:

> *I think psychologically I associate using a condom with putting in a poor performance. There's a psychological thing there where I think I can put in a better performance if I bareback.* (Jay-Jay, 37)

Marvin reflected on some of the physiological challenges experienced as one gets older and how using condoms hindered the ability to achieve and maintain an erection:

> *You get older and having an erection doesn't come quite so easily. You're halfway through something and you try to put on a fucking condom, and it gets on the wrong way, and then it's [your erection] gone.* (Marvin, 58)

However, despite the negative perceptions of condoms, there was appreciation of the risks associated with condomless sex and this resulted in feelings of anxiety, anger and guilt after episodes of unplanned condomless sex:

I was worried. I felt worried. I was shook thinking she might have a STD and was panicking a bit. (Ashley, 20)

I'd use 3 words! Angry, disappointed and guilty. Angry because I should know better. Disappointed because it shows a sign of weakness that there's times where you're fondling with a girl and you're like "lemme just put it in once", she's like "oohh ok then" and then it becomes full blown sex without a condom, and you start thinking "aah crap". And guilty because that technically is a life and if a girl has an abortion, you're terminating a life. (Jay-Jay, 37)

For some participants, preventing STI acquisition was described as their primary motivator for using condoms but for various reasons.

The suspicion that a sexual partner was actively having sex with other men was a motivating factor in the decision to use a condom for protective purposes:

If I had an inkling that they were sleeping with other people then yh, it [the condom] just went on. (Daniel, 24)

For Jay-Jay, this was the primary reason for their use, over and above for contraceptive purposes:

I think first and foremost it's STI prevention. I'm not saying abortions are a form of contraception, but in the worst-case scenario there's always that as a plan b. I just think STIs, especially AIDS, scare the hell out of me. I'm fortunate that I've never contracted an STI but I know people that have and it's not pleasant when they're telling you that it burns when they pee, or they have a horrible itch. It's just always made me feel getting an STI, that's gonna cause you some level of discomfort. As I said, unplanned pregnancies, you can always discuss an abortion. (Jay-Jay, 37)

For Ryan, the embarrassment associated with subsequent transmission of an STI to other partners served as a motivator to prevent STI acquisition:

I think giving someone an STI, it's kind of embarrassing in a way. It's embarrassing because a woman would think you're not clean or you don't know how to strap-up. For me personally, I see it as an attack on my personal hygiene. The fact that I'm

> *having multiple sexual partners and not having regular tests between them, it's kind of like a hygiene problem. Women like people with good hygiene.* (Ryan, 34)

Where main partners were unaware of other partners, condom use was motivated by a determination to maintain this secrecy through prevention of STI acquisition:

> *Don't get caught cheating first of all because if you catch something then she'll definitely know that I've had sex with another girl*. (Ashley, 20)

> *What I see certain man go through as a result of passing on fuckree [an STI]. In my case there'd be no excuse how the fuck, how the hell, without her doing it as well, how I could catch an STI.* (Simon, 50).

Others identified pregnancy prevention as their primary motivator for condom use. Similarly to STI prevention as a motivator, various reasons underpinned the prevention of pregnancy as a motivator.

For some participants, the short-term and treatable nature of common STIs in comparison to the lifelong and substantial impact associated with pregnancy influenced the identification of pregnancy prevention as a key motivator for condom use:

> *STDs are curable so even though they're like not a good thing to have or anything, it's something that you can get rid of more often than not, but babies aren't*. (Kamal, 18)

> *If you have a kid then it's life changing, whereas if you get the short end of the stick in Chlamydia or Gonorrhoea, or something like that that can be cured, then it's not. You live to tell another day. If you have a child and you wanna do right by the child, it's a massive impact on your life. We care about having a child too early. We're not really caring about the actual health risks involved in penetration*. (Anton, 29)

For Daniel, his current socioeconomic circumstances influenced his decision to identify pregnancy prevention as his primary motivator for condom use:

> *I don't need a kid and I don't need to run the risk of having a kid. I should minimise the risk of bringing a life into this world. I'm not ready because I'm broke and unemployed right now so if someone came and put a child on me I'd be done out here.* (Daniel, 24)

Martin and Jay-Jay talked about a combination of priorities and partner-specific condom use motivations that were largely dependent on their perceptions of the sexual behaviours of partners, co-parenting compatibility and mothering ability of sexual partners in the case of an unplanned pregnancy:

> *It varies. If you suspect a girl is sexually promiscuous, then that [reason for using condoms] becomes an STI. Whereas, if you don't suspect she's sexually promiscuous, but you don't see her as the mother of your children, that becomes [reason for using condoms] pregnancy. God forbid we were to bring a child to this earth and God forbid that I pass away, how would my child be taken care of?* (Martin, 41).

> *Any girl, whether it's wifey or casual, I always think "in the worst-case scenario, how would I feel if this person was pregnant for me?" and ask myself "could I see myself at least co-parenting a child with this person or I DO NOT want this woman raising a child for me.* (Jay-Jay, 37)

This subtheme centred around the meaning and practices of condom use. Participants disclosed negative experiences of using condoms which resulted in negative attitudes towards condom use and a perception of condoms as inconvenient, awkward, artificial, and capable of reducing sexual performance. There was expression of mixed STI prevention and contraceptive priorities in their use which reiterated some of the meanings discussed in subtheme 1.

However, despite this, the importance of condoms was acknowledged and influenced motivation for condom use. For participants identifying STI prevention as their motivator for condom use, this was often to prevent embarrassment associated with transmitting an STI, fear of discomfort associated with STI symptoms and to prevent transmitting an STI to an unsuspecting main partner. For those identifying pregnancy prevention as a motivator for condom use, this was influenced by personal socioeconomic circumstances, perceptions on the mothering ability and co-parenting compatibility of sexual partners, and the lifelong and substantial impact of pregnancy in comparison to the treatable nature of common STIs.

3.1.5.3 Subtheme 3: Accessing and engaging with sexual health services

This subtheme will discuss the participants' experiences of accessing and engaging with sexual health services alongside feelings regarding how sexual health services could better engage Black men.

All participants disclosed experience of using sexual health clinical services. This was generally in response to experiencing STI symptoms:

> *Things were itching, things were scratching, or things were dripping (LAUGHS) and so it was important to get them seen to*. (Marvin, 58)

> *I had symptoms. My pee was on fire. I was peeing a flamethrower (LAUGHS). It hurt, it was discomfort and to be fair, it came on literally like the day after*. (Daniel, 24)

> *Just one clinic once when I had a scare. Other than that, it was fine. But I've never really had to use them a lot.* (Simon, 50)

Some participants expressed embarrassment as a present feeling when accessing sexual health services:

> *It's bloody embarrassing because sometimes you might bump into someone that you know at the clinic. I'll tell the honest truth, often enough you bump into someone you know in the clinic*. (Dwayne, 46)

Which for others was compounded by the lengthy wait to see an appropriate practitioner:

> *It was kind of, you turned up somewhere, you queued for ages with loads of people around you looking embarrassed. You're looking embarrassed, they're looking embarrassed. Everybody's kind of trying not to look so much at each other. You wait for ages, be called by a number, see the nurse, then another nurse, then see another nurse. It feels like you have to see a whole pile of people before you saw the doctor.* (Marvin, 58)

Inconvenience around access was seen by some as a barrier and this was largely regarding a lack of walk-in appointments, prebooked appointment slots and opening times that were inappropriate for employed people:

> *They open at certain times and obviously because I'm working, I can't attend certain days. They were open from 9:00 until 2:00. I thought it would be a walk-in clinic, I'd see someone straight away. That wasn't the case. I had to come back on another day. None of the days that I could have done so I just forgot about it. Sometimes you try so hard and then when you get knocked back, especially with things like this, you just let it be.* (Ryan, 34)

Despite feeling that racially underpinned stereotypes were upheld by staff in sexual health services as discussed in theme 2, subtheme 1 "the big R", experiences when engaging with sexual health services were largely positive, professional, and needs-focussed:

> *I don't have a problem the service, the way they talk or treat you. When I had gonorrhoea, I got asked what happened. I could have made up a story. I told the woman the truth and she was like "well, that's not good is it" (LAUGHS). They've seen probably so much more and heard worse stories than mine. The service itself is calm. They didn't make it embarrassing or anything.* (Daniel, 24)

> *It was quite good, because obviously it's confidential the way they treated it. Everything that they said will take place, took place. Would I have used it again? Oh, hell yes. Because in my eyes, they're there for a reason so I would have definitely used it again*. (Simon, 50)

> *It was a positive experience. The woman came to me, she was friendly, told me what the deal is and what's gonna happen. It was very friendly, very open and helpful to be honest*. (Kamal, 18)

Some participants felt that services could do more to better engage Black men to meet their sexual health needs. A lack of awareness was identified as a sexual health need of Black men with primary care services identified as being well positioned to specifically target Black men for sexual health promotional purposes as is done in other areas of health:

> *Engaging Black men more. Promote more. That's the two main things. I think if there's more stuff tailored for Black men, it needs to be promoted more.* (Simon, 50)

Ryan suggested primary care services could adopt an alert system to promote sexual health to Black men as done with young people under 25 years as part of the National Chlamydia Screening Programme:

> *Having an alert for top priority people. I would say more promotion, more awareness. More concise awareness, I feel that we need more of that*. (Ryan, 34)

More education was also seen by this group as a sexual health need for Black men with a suggestion that services could utilise platforms that currently and routinely attract large audiences of Black men as educational and promotional sites. Martin discussed learning about HIV outcomes through listening to a podcast:

> *Educate Black men on HIV because I didn't know, well until I listened to a podcast one time and it was talking about how basically for those who have HIV, it's not the end of their life. That HIV doesn't equal death. Whereas before that podcast, I was quite ignorant to HIV*. (Martin, 41)

Lack of education was identified as a major issue amongst young Black men presenting a need for schools to engage young Black men in accurate education from a young age:

> *I'd say start from schools. Start infiltrating schools because Black boys at an age, they're quite, I would say not informed as much. I don't want to say ignorant, but they're just not being informed*. (Martin, 41)

> *I don't remember nothing about sex education in school when I was growing up, nothing. I wish I learned it, whether at school or my parents and I didn't get it from either.* (Dwayne, 46)

Some participants felt that sexual health services should build partnerships with Black organisations to facilitate targeted outreach sessions for easy, accessible, and convenient education and STI testing:

> *I think we need to have early intervention where we encourage spaces where we as Black men congregate like barbers and food stalls markets, and just signpost. Greater signpost to sexual health services. I know it sounds dumb, but even at raves, even if they have some kind of cubical in the toilet where while you're here in the toilet, why not have an STI test. You can pee in the bottle, quickly provide a blood sample and no*

one will be none the wiser. Maybe some initiatives like at afro hair and beauty, or wireless festival. Maybe just have a sexual health stall with a discreet tent that people can go in. (Jay-Jay, 37)

Obviously, they'll have to tap into Black organisations. Whether online, or face to face organisations. There are loads of Black organisations still operating. Nightclubs, places like that. Yes, people are going there to rave but why not? Why not do it in a social gathering? Nightclubs, cinemas, any social place where people gather. Wine bars, sports arenas. Even music concerts. (Simon, 50)

This subtheme has presented the participants experiences of accessing and engaging with sexual health services. Participants largely expressed positive experiences when accessing sexual health services with staff acting professionally and polite. Increasing promotion, awareness and education were suggested as ways which sexual health services could better meet the needs of Black men. Suggestions were made for sexual health services to build relationships with Black organisations to facilitate targeted outreach in a community friendly manner.

4.0 Discussion

This study aimed to explore the sexual health experiences and behavioural motivators of Black heterosexual men in London. The study obtained a rich account participants' lived experiences and provides an understanding of their thoughts around unhealthy sexual behaviours and motivators of protective sexual behaviours.

This chapter will discuss the findings in relation to the research questions alongside implications for clinical and educational practice, recommendations for future research and methodological limitations. Finally, the main conclusions of the research are presented.

4.1 Revisiting the research questions.

In attempting to develop a greater understanding of the sexual health experiences and motivators of Black heterosexual men, the following research questions were explored:

1. What does it mean to be a man?
2. How does the experience and understanding of being a Black man inform sexual attitudes, relationships and behaviours?

3. What do Black heterosexual men describe as their motivators for condom use and how does this inform their STI and pregnancy prevention efforts?
4. What is the experience of racism among Black heterosexual men and how does this experience inform engagement with sexual health services and interventions?

4.2 Research question 1: What does it mean to be a man?

Perceptions of masculinity and manliness were age-dependant. As discussed in the introduction chapter, findings from several studies (Fenton et al., 2005; Wayal et al., 2017) indicate that Black men are more likely to report concurrent sexual partnerships, with reasons less understood. In this study, perceptions and demonstration of masculinity changed with age. In theme 4 "liberal London", there was an acknowledgement of pride and status associated with having multiple sexual partners during adolescence. This was unsurprising considering the common sexual risk-taking and experimentation observed during adolescence which sees young people more frequently engage in concurrent sexual partnerships (Doyle, 2016; Forsyth & Rogstad, 2015; Nalukwago et al., 2018; Tanton et al., 2018). Furthermore, amongst young men, feeling masculine is said to involve success with women alongside respect from peers (Gerressu, 2016). However, in London, these norms and behaviours are not unique to adolescent Black boys, but generally observed amongst adolescent boys (Connell et al., 2004).

There was resistance from participants regarding associating masculinity and sexual behaviours including number of sexual partners post-adolescence. This aligned with the argument that masculinity is fluid rather than fixed and static (Talbot & Quayle, 2010; Watson, 2015). Generally, post-adolescence, perceptions of masculinity challenged the hypermasculine narrative often assigned to Black men and contradicted the suggestion that marginalised men engage in risky behaviours, including sexual behaviours, as a way of upholding and demonstrating masculinity to others (Fleming et al., 2016; hooks, 2004; McDaid et al., 2019). Rather, throughout theme 1 "accountability and responsibility: a real man" several references to leadership qualities were made in relation to perceptions of how a real man should behave whilst accountability and responsibility to family and close ones were upheld as masculine traits. Participants emphasised the importance of being a role model, setting good examples, being approachable and using one's life experiences to guide younger generations. Importantly, perceptions on masculinity and manhood were

significantly influenced by life experiences and interactions and observations of elder relatives including parents, siblings, cousins and uncles.

Whilst all participants disclosed experience of engaging in concurrent sexual partnerships, and therefore highlighting a contradiction between their perceptions of masculinity and their behaviours, the reasons behind the concurrent partnerships were said to be unrelated to demonstrating masculinity. Boasting about or openly demonstrating having multiple sexual partners was said to fade post-adolescence, with participants indicating that this would attract criticism from peers in adulthood. A possible explanation could be the normalisation of the behaviour after several years of demonstration. Normalisation is a sociological concept described as a process which sees practices become routinely embedded in social contexts through the individual or collective enacting of them (May & Finch, 2009). Participants also spoke about enjoying the variation in experiences with different women. Nevertheless, explanations for the behaviour should be explored greater in future research.

When specifically discussing Black masculinity, living in a country where one is racially marginalised significantly impacted participants' perceptions of Black masculinity. Within theme 2, subtheme 2 "having to be better and stronger than the average: experiences of the Black man", a negative tone, underpinned by experiences, characterised participants descriptions of Black masculinity and subsequently their perceptions of what being a Black man meant. Being a Black man meant accepting that racism exists at individual and institutional levels and remaining mindful of the negative way that Black men are socially perceived. Consequently, being a Black man meant having to work twice as hard and be twice as good as their White counterparts for similar achievements. Being a Black man meant being subjected to and judged according to racist stereotypes that permeated multiple facets of participants' lives from interactions with institutions to expectations on sexual anatomy and performance.

As a result, strength and resilience were identified as key attributes Black men must possess. However, in this context, strength and resilience were in relation to wellbeing as opposed to physicality and referred to being able to cope with the psychological tax and pain that accompany experiences of racism whilst continuing to provide support to family, friends and loved ones as expected of Black men. A systematic review exploring how Black

people cope with racism reported that Black men more frequently adopt passive strategies such as ignoring rather than actively visible strategies when confronted with racism because of the concentrated scrutiny and surveillance their behaviours are subjected to alongside the harsher way that society punishes Black men involved in conflict (Jacob et al., 2022). It was for this reason that participants identified strength and resilience as key attributes that Black men must possess. However, whilst these are often viewed as positive traits to possess, this can result in perceptions of Black masculinity being reduced to the characteristics that Black men must demonstrate to survive and succeed as a racially minoritised member of society rather than attributes of thriving or positivity.

This complexity in understanding how Black men should 'be' is echoed in other findings from studies (Chaney, 2009; Hunter & Davis, 1992). Hammond & Mattis, (2005) reported that Black men categorise manhood as a multidimensional concept with responsibility and accountability the most endorsed traits. However, the question remains, how do those who fail to achieve the leadership ideals described by participants as markers of manliness resort to demonstrating masculinity? Work is needed centring the voices of Black men in research that explores honest and reflective accounts of how Black men perceive, experience, and demonstrate their masculinity in different contexts.

4.3 Research question 2: How does the experience of being a Black man inform sexual attitudes, relationships and behaviours?

Participant experiences highlighted three fundamental ways which being a Black male informed their sexual attitudes, relationships and behaviours.

4.3.1 Music and media content

Firstly, theme 3 "sexual socialisation" highlighted early and frequent exposure to hypersexualised Black stereotyping in media content that were popular within the Black community including films and hip-hop and dancehall music. Consequently, music videos and films became significant in the promotion and normalisation of concurrent sexual partners. These findings aligned with a previous qualitative study (Wayal et al., 2020) where participants perceived Black Caribbean popular music to encourage concurrent sexual partnerships, especially among men and young people.

Hip-hop and dancehall have been identified as two of the most popular musical genres amongst Black youth whilst containing more descriptions and depictions of sexuality, eroticism and heavy sexual connotations where women are portrayed as disposable sexual objects for males with insatiable sexual appetites (Peterson et al., 2007; Primack et al., 2008). It has been argued that consumption of graphical musical content can impact adolescent sexual behaviour, particularly amongst young men because of the delivery from a masculine perspective (Crawford, 2010).

Further significance appeared because the artists delivering these messages were successful Black men. As emphasised in theme 3, subtheme 2 "dancehall, hip-hop and "how to be a player"", the lack of maturity observed in pre-teenage years when participants started accessing these media content, and throughout adolescence meant they were unable to regard the content absorbed as produced for entertainment purposes solely. This matters because young Black men are said to find role models in male artists seen on television as these artists are often perceived as being relatable. They are usually of a similar age, usually come from disadvantaged backgrounds and vocalise stories of going from rags to riches (Greene, 2008). An idealisation is developed which measures success in overcoming poverty and marginalisation through sexual promiscuity. Consequently, rap and hip-hop artists, record producers, executives and merchandisers have become positioned as role models for a generation of young Black men who are obsessed with achieving success and status through acquisition of wealth, material consumption and the indiscriminate pursuit of sexual relationships with women (Kitwana, 2002). However, rather than viewing money and sexual partners as a consequence of success, the lack of maturity when the content was accessed meant participants viewed these as a measure of success.

4.3.2 Sexual stereotypes and racialised pornography

Exposure to racist sexual stereotypes and sexual expectations of Black male sexuality informed participants' sexual attitudes and behaviours. In theme 2, subtheme 3 "big dicks and sex on tap: the sexualisation of Black men's bodies", participants described being exposed to sexual stereotypes from an early age through racialised pornography and experiencing fetishization. The impact of consuming racialised pornography was discussed in theme 3, subtheme 3 "the double-edged sword that is porn" and included distorted perceptions of Black male genitalia, sexual performance and number of sexual partners.

Several assumptions about Black men's penises have been projected across Europe and America throughout history and these include the beliefs that Black men possess giant penises and consequently inexhaustible sexual energy (Meiu, 2009). These racist stereotypes and generative colonial ideologies are a major contributor to the sex tourism industry observed across several African and Caribbean countries which sees large amounts of White women purposefully travelling to these countries seeking opportunities to engage in sexual acts with exoticised and fetishized Black men (Makoni, 2016; Meszaros & Bazzaroni, 2014).

Whilst not under the guise of tourism, participants experienced similar instances of being fetishized and wanting to be "tried". Accessing racialised pornography further compounded the awareness of expectations regarding the sexual anatomy and performance of Black men. These in turn led to a belief amongst participants that they should be having sex frequently and engaging in unwanted sexual encounters.

As highlighted in theme 2, subtheme 3 "big dicks and sex on tap: the sexualisation of Black men's bodies", consequences of exposure to racist sexual stereotypes included unwanted sexual encounters driven by insecurity around Black masculinity. There was a potential for psychosexual consequences associated with having to navigate stereotypes and trying to achieve unrealistic expectations alongside the avoidance of medical services due to fear of judgement. Ultimately, the experiences of participants indicated that long-standing racist sexual stereotypes, behavioural distortions and barriers to services create a risk to the sexual health of Black men.

4.3.3 The lack of parental support

Theme 3, subtheme 1 "not parents, but friends, the "olders" and other role models" revealed intergenerational factors related to the stigmatised nature of sex within some Black communities which resulted in participants relying on friends and older peers in the community for RSE, advice and information. Consequently, whilst absorbing sexually explicit materials through song lyrics, music videos and films, and being exposed to sexual stereotypes and expectations, participants were unable to seek advice, guidance, and accurate information from parents, instead turning to friends and older peers. The greater influence of peer-based messaging further reinforced harmful stereotypes with participants

disclosing being subjected to a culture promotive of having multiple partners which saw them idolise the way older peers successfully pursued and treated women.

4.4 Research question 3: What do Black heterosexual men describe as their motivators for condom use and how does this inform their STI and pregnancy prevention efforts?

The findings of the study in relation to this research question provide an account of thought processes underpinning condom use and condomless sex, with implications for the design of interventions aiming to increase condom use amongst Black men.

Experience of concurrent sexual partnerships were common although not consistently current. The practice of having concurrent sexual partnerships was influenced by numerous factors including sexual socialisation as highlighted in theme 3 “sexual socialisation”, alongside area of residence. In theme 4 “liberal London”, participants declared that growing up and living in London exposed them to a culture promotive of the early onset of sexual activity and having multiple partners. Consequently, active efforts were exerted to demonstrate a multiplicity of partners to peers during adolescence for internal and external validation.

Similar to the findings of a previous study (Wayal et al., 2020), when in main-plus concurrent partnerships, participants identified a main partner who was labelled “wifey”, “main chick” or plainly “number one” whilst non-main partners were assigned terms such as “side chicks” and “number two or three etc”.

Throughout theme 5 “sexual behaviours, relationships, and health”, it became apparent that motivators of condom use were multifaceted, situation dependent and significantly moderated by factors concerning sexual partners. A threat appraisal of sexual partners was described through which condom use was decided. Appraisals were subjective in nature and often dictated by factors including current socioeconomic circumstances such as employment status, nature of relationship with partners, and various perceptions about sexual partners. Ultimately, the main determinants of condomless sex were trust and familiarity with a partner, although this was not always a straightforward decision.

Condom use motivated by STI prevention was present in both main-plus and non-main concurrent sexual partnerships. To recap on the definitions of these terms, “main plus partnerships” are where an individual has a main partner who they are in a “relationship”

with alongside other non-main partners, and “non-main partnerships” are where an individual has multiple, non-committed partners (Wayal et al., 2020).

4.4.1 Condom use with main partners

Generally, the relationship with a mutually exclusive or main partner was perceived as possessing the seriousness, familiarity and trust that eliminated the motivation to use condoms for STI prevention. In theme 5, subtheme 1 “main vs sides: actions speak louder than words”, participants expressed using condomless sex as an action to demonstrate trust and seriousness to a main partner. In this case, when condoms were used, they were underpinned by pregnancy prevention intentions as the primary threat was perceived to arise from the potential lifelong implications of an unintended pregnancy, contradicting the narrative of the “absent Black father” (Coles & Green, 2010; Reynolds, 2009). As a result, where a mutually exclusive or main partner was in use of a hormonal contraceptive, condoms were abandoned altogether. Condoms were maintained where no hormonal contraceptive was in use and pregnancy prevention was intended.

These findings concur with the findings of a previous study which reported that participants in more serious relationships were more likely to use a hormonal contraceptive (Manlove et al., 2014). A reason for this could be that those in more serious relationships often consider the abandonment of condoms to enhance intimacy (Manlove et al., 2003).

Whilst participants were happy to abandon condom use with mutually exclusive or main partners if they appraised little threat of unintended pregnancy, it was unclear whether the partner’s use of hormonal contraception was self-informed or requested by participants.

4.4.2 Condom use with non-main partners

Theme 5, subtheme 2 “strapping up” highlighted factors motivating condom use, including with non-main partners.

In “non-main” partnerships, motivation for condom use was underpinned by a lack of trust and familiarity, and suspicions that partners were sexually involved with other males. In addition to this, within “main-plus” partnerships, factors motivating condom use with non-main partners extended to include preventing the potential of transmitting an STI to a main partner.

With non-main partners, condom use was further moderated by perceptions of a partner's sexual behaviours outside of their partnership, and this was the case whether participants had multiple partners or a single partner. This aligned with findings from a systematic review which reported that men increase their use of condoms in situations where they do not trust that their partner is being faithful to them (Fehr et al., 2015). A lack of trust or suspicion that a partner was concurrently sexually involved with other males was perceived as a threat to sexual wellbeing which could be eliminated by using condoms. The perceived lack of seriousness within these partnerships also necessitated condom use.

With non-main partners, alongside socioeconomic circumstances, motivation for condom use was further moderated by perceptions of external factors including the parenting ability of partners.

The findings of this study align with existing literature (Carey et al., 2010; Chatterjee, 2006; Frye et al., 2013) which indicate that amongst Black heterosexual men, condom use behaviour is often moderated by partner type, hence condoms are generally used with new or casual partners and abandoned as relationships become more serious.

Regardless of appraisal outcomes, significant numbers of men fail to use condoms consistently with non-main partners despite intending to do so and consequently increasing their STI risk (Hicks et al., 2017). This was also the case in this study as participants discussed the loose application of condoms with some non-main partners. In theme 5, subtheme 2 "strapping up", participants described condom use as having a detrimental impact on sexual performance and levels of sexual intimacy whilst creating an awkward encounter. Importantly, in this study, the complicated relationship between motivating factors and decision making created both overlapping and ignoring of motivating factors in a situation-dependent manner. Furthermore, research (Bowleg et al., 2021) has suggested that the lengthy nature of some non-main partnerships creates a similar level of familiarity that typifies many main partnerships thus rendering condom use as less imperative than with a first-time, unknown or one-time sexual partner. Unfortunately, exploration of non-main partnership duration and perceived seriousness fell outside the scope of this study.

4.5 Research question 4: What is the experience of racism among Black heterosexual men and how does this experience inform engagement with sexual health services and interventions?

As a group of racially marginalised men, participants experienced challenges across many aspects of their lives and a significant proportion of these were underpinned by racism as highlighted throughout theme 2 “the Black man’s battle”.

Whilst some participants were born in the 21st century, others had grown up in 1970’s Britain and recalled their experiences of racism and those of their parents which made their lives harder. Whilst unsurprising that all participants had experienced racism, what became apparent was that the way racism was experienced had changed. Racism had become less direct and obvious. Gone were the days of National Front demonstrations and where Black people would routinely have racial slurs hurled at them in the street, particularly in London. This matters because London remains the most ethnically diverse region in England (Office for National Statistics, 2020) and continues to diversify. Figures from an annual population survey indicated that in London, between 2012-2020, the Black population alone increased from 963, 000 to 1,058,000, an increase of 95, 000 (Office for National Statistics, 2022). The landscape of racism, and therefore experiences of it had changed as discussed throughout theme 2, subtheme 1 “the big R”. Racism was now experienced as structurally perpetrated by institutions.

Historically, when discussing ethnic and racial health inequalities, discourse has centred on social determinants of health including socioeconomic status, education, neighbourhood (Braveman & Gottlieb, 2014; Hill-Briggs et al., 2021; Paremoer et al., 2021). Often, explanation for inequalities in health outcomes amongst Black people is attributed to Black people being more likely to experience SED; live in deprived neighbourhoods; be unemployed; and live in lower quality housing (Cabinet Office, 2017). These social determinants of health are also relevant to poorer sexual health outcomes with structural factors, such as SED, poverty and unstable housing all associated with increased STI risk, including HIV (Dunlap et al., 2013). More recent research in London highlighted how socioeconomic factors exacerbate health inequalities amongst racially minoritised groups, including their access to sexual and reproductive health services (Love Sex Life LSL Partnership, 2020).

Until recently, there was little acknowledgement on the core role of institutional and structural racism in causing the causes of health inequalities, a term labelled “causes of the causes” (Marmot, 2018). Consequently, an understanding of racism is fundamental to understanding ethnic inequalities in health outcomes (Marmot & Wilkinson, 2005).

Structural racism in healthcare is evident through the increased likelihood of racially minoritised communities encountering negative pathways through care, poorer access to effective interventions, and poorer health outcomes. Whilst these racial and ethnic disparities are real, the causes are often blamed on prespecified genetic, cultural, and relational properties amongst racially minoritised communities (Nazroo et al., 2020). Often ignored is that structural racism causes racially minoritised groups to experience increased exposure to adverse social and economic conditions alongside their day-to-day experiences of discrimination, and it is this structural racism that results in racially minoritised communities experiencing disadvantages in the social determinants of health (Marmot et al., 2020). This aligns with the suggestion that disparities in sexual health and HIV outcomes amongst Black people could be strongly linked to the experience of growing up with a Black identity in a context of structural racism rather than being of a racial or cultural background (Adimora & Schoenbach, 2005). An example of this is highlighted in the structural concentration of Black people in the most deprived neighbourhoods (Nazroo, 1998), and the role of SED and poverty in elevated STI/HIV risk (Hixson et al., 2011).

Constantly articulated throughout theme 2 “the Black man’s battle”, racial biases were said to be embedded at the core of society, organisations, institutions and government which marginalised participants and worsened their experiences. The police and criminal justice system, the education system, the workplace and the health service. Participants expressed that these institutions and organisations, some representing the state, had treated them differently because of their race. However, unlike avoiding certain regions that participants felt would increase susceptibility to direct and individualised racial abuse, these were institutions and organisations that could not be avoided, and participants were forced to engage with from a young age. This created a lack of trust in institutions and organisations, and a perception that they did not care about Black people.

In theme 2, subtheme 3 “big dicks and sex on tap: the sexualisation of Black men’s bodies”, experiences of institutional racism were identified to inform engagement with sexual health

services in two distinct ways. A fear of being judged, but also a fear of projected stereotypes when accessing sexual health services. Firstly, participants were aware of the hypersexual label often assigned to Black men and this created fear that disclosures regarding number of sexual partners would spark judgement and further reinforce the practitioner's perception of Black men as hypersexual. Secondly, a fear of judgement regarding genitals where examination was required, especially amongst those who felt that their genitalia did not mirror society's perception of what Black male genitalia is supposed to look like.

There was a feeling that psychosexual issues such as erectile dysfunction (ED) contradicted expectations on Black male sexuality and this could result in delayed seeking of treatment. Whilst no participants disclosed currently or previously experiencing ED, feelings may be reflective of their beliefs which may subsequently influence their approach were they to develop ED in the future.

Whether participants were being judged or not, the fear of being judged and the emotional consequences of this remained with them whenever they accessed sexual health services.

Fortunately, despite these fears, experiences of accessing sexual health services were overwhelmingly positive, with barriers mitigated by positive experiences of prior engagement as presented in theme 5, subtheme 3 "accessing and engaging with sexual health services". Prior positive experiences increased trust in services and promoted that sexual health services could be relied upon when successfully accessed. These findings concurred with the findings of a literature review exploring young Black men's barriers and facilitators of accessing sexual health services which revealed that trust in the health care system and providers was amongst the top facilitators influencing young Black men's engagement with sexual health services (Burns et al., 2021).

The findings from this study indicate a willingness amongst Black heterosexual men to access sexual health services when perceived to be required. However, what remains unknown is how the experience of institutional racism and racist stereotypes impact motivation to engage with interventions aiming to reduce risky sexual behaviours.

4.6 Implications for practice

The study findings have implications for practice across the health and education sectors that could contribute to improvements in the sexual health of Black heterosexual men.

4.6.1 Formal RSE

Firstly, the unique way that participants experienced sexual socialisation identified a role for school based and external RSE providers. It is important that young Black men are engaged in RSE that appropriately explores and counteracts the messages absorbed from peers and when accessing explicit media content including music, film and racialised pornography. This is one way that formal school based RSE can better meet the needs of young Black men. As currently done with pornography (PSHE Association, 2022), an exploration of media content can provide young Black men with accurate information that enables them to make informed decisions about their sexual relationships. Content that solely focuses on biological elements is likely to neglect the needs of young Black men who may be absorbing sexual messages from relatable hip-hop and dancehall artists who are perceived to better understand their social positioning than their White female schoolteacher as they, more often than not, are (Greene, 2008). Resources used for RSE should contain figures relatable to young Black men.

4.6.2 Parent-child sexual communication

A role for parents as educators was also identified. Whether through formal or informal dialogue, or observations, it is important that young Black men are exposed to realistic depictions and accurate discussions regarding sex and relationships to counteract messages and expectations acquired from a young age about sexual lifestyles and behaviours.

The protective nature of parent-child sexual communication (PCSC) has been extensively discussed (Widman et al., 2014, 2016; Wright, 2009). The influential role of parents on the sexual socialisation of children and young people means parents can support the development of psychological and sexual wellbeing as the higher perceived quality of PCSC for sensitive topics like sexual pleasure and behaviours is associated with increased sexual self-efficacy and self-esteem, body esteem and sexual assertiveness (Astle & Anders, 2022). Furthermore, a systematic review exploring PCSC and adolescent sexual behaviours demonstrated consistent links between PCSC and more positive sexual attitudes and safe-sex efficacy amongst adolescents which may then influence sexual intentions and subsequently behaviours. Importantly, the nature of communication, including extent and content can influence effectiveness over adolescents' sexual cognitions (Rogers, 2017).

Encouraging PCSC with particular attention directed to the relational elements of the conversations offers a promising approach to the promotion of sexual health amongst young Black people (Bonafide et al., 2020).

The stigmatised nature of sex within some Black communities (Cornelius & Xiong, 2015; Dennis & Wood, 2012; Kuo et al., 2016) may require development of interventions to equip parents of Black boys with the knowledge, skills and confidence to facilitate PCSC.

4.6.3 Outreach work

With presence of symptoms prompting visits to sexual health clinics, sexual health services should conduct outreach to engage asymptomatic Black men who may not be accessing routine STI testing because of a lack of symptoms. The asymptomatic nature of many common STIs exacerbates the importance of asymptomatic screening. Several suggestions were provided regarding how sexual health services can better engage Black men including outreach at venues that are largely populated by Black men.

To prevent inappropriate racial profiling and the unintentional reinforcement of racist stereotypes regarding Black male sexuality, outreach should be planned and conducted sensitively. As a starting point, services should seek to understand how Black men within their local community prefer to access services and adapt to meet these needs. Services should also build relationships with community organisations and involve representatives of these organisations in service planning to ensure that when outreach is conducted, it is done so in a culturally sensitive manner.

4.6.4 Assessing for unwanted sex

Finally, the findings from this study have implications in the way that sexual vulnerability and domestic violence and abuse (DVA) is assessed amongst Black heterosexual men.

DVA Guidelines produced by the National Institute for Health and Care Excellence (NICE) recommend that frontline practitioners in health and social care settings should be directly asking patients about abuse and that asking all patients “should be a routine part of good clinical practice” in some settings, including sexual health services (National Institute for Health and Care Excellence, 2014). Consequently, the sexual violence group at BASHH produced guidelines (Sacks et al., 2016) to support sexual health services enquire about DVA. The guidelines recommend that practitioners could ask “Have you ever been physically

hurt or made to feel afraid by someone close to you?". Alternative lines of enquiry include "have you recently been emotionally, verbally or physically hurt by someone close to you?" or "are you at risk of violence or abuse from anyone close to you?" (Sacks et al., 2016). Whilst these lines of enquiry may be relevant to some groups within the population, they fail to acknowledge the context that participants discussed unwillingly engaging in sexual activity. Participants did not report being physically, emotionally or verbally hurt, or feeling afraid of sexual partners yet felt pressured into sex.

Considering that men are less likely to disclose experiences of sexual violence (Bullock & Beckson, 2011), and if they do, typically delay disclosing until many years later (Walker et al., 2005), practitioners should avoid creating extra barriers by utilising lines of enquiry that are inconsiderate of the context in which Black men unwillingly engage in sexual encounters. Lines of enquiry should better reflect the unwanted sexual contact they experience rather than solely focussing on experiencing hurt or feeling fearful of a sexual partner. For example, asking "have you recently engaged in a sexual encounter that you did not want to engage in or feel you could not reject" is more inclusive of the sexual vulnerability participants experienced which did not include the use of force, and in line with findings from a study (Weare, 2018b) exploring the lived experiences of "forced-to-penetrate" victims. "Forced-to-penetrate" is described as "where a male is forced to penetrate the perpetrator's vagina, anus or mouth using his penis and without his consent" (Weare, 2018a). The study revealed that the most common strategy used by female perpetrators were blackmail and coercion, including spreading lies about the male victims, threatening to spread rumours and applying persistent pressure after victims rejected sexual invitations (Weare, 2018b).

4.6.5 Trust as an emerging determinant of health

The findings of this study contribute to the increasing recognition of trust as a determinant of health. Trust is regarded as a vital trait in all human social interactions and consequently, a level of trust is important for transactions between human beings (Gopichandran & Chetlapalli, 2013).

Trust in healthcare providers is fundamental in increasing effectiveness as when patients seek health care, this involves a degree of vulnerability from trusting the provider to do the best according to their knowledge, training and ability to help them find a cure or heal

(Abildsnes et al., 2012; Hall et al., 2001). Patients need to trust and expect that the healthcare system will provide them with appropriate diagnoses and treatment, not exploit them, and behave in a transparent manner with a genuine interest in their wellbeing (Caterinicchio, 1979).

Lack of trust in the health service, particularly amongst racially minoritised communities discourages these populations from seeking help and support when needed (Georghiou et al., 2022). This was exemplified during the rollout of the Covid-19 vaccine, during which vaccine uptake was lowest amongst Black ethnic groups (Razai et al., 2021; Robertson et al., 2021). The most commonly reported barriers to vaccine uptake were lack of trust in government institutions, lack of trust in information, and mistrust in the vaccine and the healthcare providers administering or promoting it (Halvorsrud et al., 2022), highlighting the fundamental role of trust in accessing preventative medical interventions. Trust was reported to be undermined by beliefs in systemic racism, previous cases of medical racism and unethical medical experimentation by vaccine developers, and personal experiences of medical racism (Bell et al., 2022).

In sexual and reproductive health, a significant body of evidence demonstrates that current practice is largely underpinned by findings from unethical medical research on historically colonised populations, and has created profound mistrust in health services amongst racially minoritised groups which exacerbate poorer sexual health outcomes amongst these populations (Love Sex Life LSL Partnership, 2020). Unfortunately, the medical profession has historically contributed to harming racially minoritised communities, including Black populations, which means rebuilding trust must occur at a systemic level (Khan, 2022). This indicates a role for national bodies in sexual, reproductive and HIV healthcare including BASHH, the British HIV Association (BHIVA), and the Faculty of Sexual and Reproductive Health (FRSH) to emphasise and promote the need to rebuild trust as a key strategy.

In this study, trust in sexual health services was encouraged by previous positive experiences and professionalism, signifying the importance of maintaining this, especially amongst patients from racially minoritised communities. Furthermore, deeply embedded distrust in services will require time and resources to address through long-term investment in partnerships and community engagement to obtain a detailed understanding of community perspectives (Halvorsrud et al., 2022).

4.7 Limitations of study

This study is subject to methodological limitations which must be considered.

Several limitations have been attributed to qualitative research and may consequently apply to this study. Firstly, rigor is argued to be more challenging to establish, assess and demonstrate. Secondly, data analysis is significantly influenced by the researcher's personal biases and assumptions which presents challenges in replicating any findings (Anderson, 2010). Finally, the smaller sample sizes in qualitative research present issues in generalising the findings to the whole population of the research (Sindelar et al., 2014).

A purposive sampling strategy was adopted to maximise the accounts of experiences obtained and underpinned the variation achieved in demographic factors like age, ethnicity, employment status and area of residence. Regardless, some factors pertinent to the sample and study design, including the focused participant inclusion criteria, may restrict the understanding of experiences obtained to participants, with transferability of the findings left to the judgement of the reader (Meyrick, 2006).

The study's focused inclusion criteria means that whilst the experiences of Black, cis-gendered, heterosexual men with good English literacy proficiency, and experience of condomless sex and concurrent partnerships have been captured, the experiences of certain subgroups including recently arrived migrants, heterosexual-identifying MSM and those with more limited sexual experiences remain understudied.

Firstly, this study recruited participants from three barbershops in London. Whilst this had logistical advantages in the recruitment phase, it limits the accounts of experiences obtained. After all, several participants expressed feeling that their experiences would have differed had they not grown up or lived in London. Secondly, of the sample, 50% were educated to degree level. Whilst there is no current data on degree attainment amongst Black men specifically, 26.4% of 25-64 year-olds in the UK have attained a bachelor's degree (Organisation for Economic Cooperation and Development, 2022). The higher educational attainment of these men may afford them certain socioeconomic privileges which results in their lived experiences being unreflective of the experiences of Black heterosexual men who occupy lower levels of the socioeconomic ladder. Finally, this study excluded gender and sexually minoritised Black people including those identifying as MSM, men who have sex

with men and women, heterosexual-identifying MSM, transgender and non-binary. Key findings therefore need to be confirmed in a study with a larger and more diverse sample.

It has been suggested that establishing relationships with community organisations that serve racially minoritised populations can facilitate recruitment (Alvarez et al., 2006; Ford et al., 2005) and therefore strengthened the study's methodological approach. However, displaying posters on social media and in barbershops placed the onus on interested individuals to contact the researcher and express an interest in participating. This may have limited the sample to those who possess an interest in the topic being studied and possess the confidence and ability to contact the researcher and articulate their interest. Whilst efforts to mitigate this were made through tasking barbers to engage all customers meeting the study inclusion criteria in discussions about the research, there could have been increased variation within the sample had the researcher adopted a proactive outreach recruitment strategy. This would have also provided opportunities for the prospective participants to familiarise themselves with the researcher and establish rapport from the point of introduction to the study rather than at the beginning of interviews.

The benefits of my position as an "insider" have already been discussed. During the interview process, there was the expression of cultural idioms and shared vernacular which resulted in an intrinsic understanding of what the participants meant that did not require constant requests for elaboration. However, this cultural familiarity may have prevented the acquisition of deeper insight which could have been obtained with further enquiries but may have come at the detriment of rapport between the researcher and participants.

4.8 Recommendations for future research

A stark dearth of research exploring Black masculinity and Black male sexuality in a UK context was uncovered during the conducting of this study. This study has added to the limited understanding of these concepts, however future research is required to increase academic understanding of the way masculinity and sexuality inform the experiences of Black men in a UK context, and to ensure that the understanding remains current and relevant. As the day-to-day experiences of Black men are often underpinned by racist stereotypes regarding Black masculinity and Black male sexuality, future research should

enable Black men to use their stories as counter-narratives against dominant discourses which seek to further marginalise them (Harper, 2009).

Whilst the current study has provided insight into the participants' sexual health experiences and motivators, alongside constructions of masculinity, experiences of sexual socialisation and expression of sexuality, the qualitative nature of this study means the findings should be explored amongst the wider Black male population to ensure relevance before being used to underpin development of interventions. Such research should expand on the focused participant inclusion criteria used in this study to maximise the understanding of experiences obtained and increase the potential for transferability. This should include some subgroups not heard from in this study including subgroups including recently arrived migrants, heterosexual-identifying MSM and those with more limited sexual experiences.

This study has shed light on how some Black heterosexual men perceive and demonstrate their masculinity, contradicting the hypermasculine label often ascribed to Black men. Descriptions of masculinity and manliness were reflective of leadership characteristics. However, what was less clear in this study was how those who fail to achieve the leadership ideals described by participants as markers of manliness resort to demonstrating masculinity. This fell outside the scope of this research and should be explored further. Furthermore, future research should facilitate a deeper understanding of Black masculinity in different contexts and across various aspects of Black men's lives.

This study also explored participants' experiences of concurrent sexual partnerships and motivators of condom use within these. However, as this study did not distinguish between recurrent and first-time, one-time and unknown non-main partners, future research and intervention developers should explore and consider the dynamics of these partnerships, and how these moderate STI threat appraisals and subsequently condom use behaviour in a UK context.

This study highlighted a lack of PCSC between participants and their parents with barriers including a stigmatised perception of sex within some Black communities. Future research should explore this further and seek to understand how young Black boys in the UK wish to be supported by their parents, including the nature of PCSC they wish to receive. This should

be complimented by research seeking to understand Black parents' experiences of facilitating PCSC, including successes and challenges encountered, to identify how to support them to confidently facilitate PCSC.

Challenges associated with recruiting Black men to research studies have been discussed extensively (Corbie-Smith et al., 1999; Ford et al., 2005, 2008; George et al., 2014; Randolph et al., 2018). Given the accomplishments of this study, a recruitment study should be conducted to establish principles of good practice for recruiting Black men in a UK context to research studies.

Finally, future research should trial the delivery of an outreach sexual health service model tailored at Black men to evidence the effect, successes, and challenges of such model.

5.0 Conclusions

This study explored the sexual health experiences and motivators of Black heterosexual men in London. The findings from the study contribute to the currently dearth understanding of Black masculinity and Black male sexuality in a UK context. The findings shed light on these understudied concepts by describing the way that participants perceived and demonstrated their masculinity and highlighting their experience of sexual socialisation, including the way that wider social and environmental contexts contributed to sexual attitudes and behaviours. Limitations of the study's focused inclusion criteria have been discussed, including the absence of certain subgroups like recently arrived migrants, heterosexual-identifying MSM and those with more limited sexual experiences. Recommendations for how to address these limitations in future research have been specified.

Perceptions of masculinity and manliness changed as participants aged. During adolescence, masculinity was largely demonstrated through having multiple sexual partners. As participants aged, this changed to revolve around being seen as a leader and meeting the needs of family and loved ones, with great importance placed on being a positive role model for the younger generation. Strength and resilience were identified as key characteristics of Black masculinity and promoted as traits that a Black man must possess for survival in social and environmental contexts where they are racially marginalised.

Being Black males significantly underpinned the sexual socialisation process for participants and subsequently informed their sexual attitudes, relationships, and behaviours. Participants were exposed to explicit media content from a young age including music, films, and racialised pornography which provided them with an initial introduction to the sexual anatomy of women and promoted multiple sexual partners. Furthermore, racist sexual stereotypes resulted in the fetishization of their bodies and created expectations on their genitals and sexual performance. These resulted in participants being targeted for sex, experiencing pressure to have sex, and developing a belief that they should be engaging in sex frequently. This was further compounded by the inability to seek advice or guidance from parents due to the stigmatised nature of sex in their community and a generational divide in perceptions of sexual relationships. Consequently, initial conversations around sex and relationships occurred with friends and older peers, further reinforcing the messages observed in explicit media content. Maturity developed during the ageing process sparked a dismissal of messages absorbed from media and peers.

Motivators for condom use were complex, multifaceted and situation dependent. Familiarity and trust with a main partner eliminated the motivation to use condoms for STI prevention. In this case, pregnancy prevention became the priority and consequently saw condoms abandoned altogether when a main partner was in use of a hormonal contraceptive.

There was an awareness of risk associated with condomless sex with non-main partners. Condom use for STI prevention was motivated by a lack of trust and suspicion that a non-main partner was sexually involved with other men. For pregnancy prevention with non-main partners, socioeconomic circumstances, and negative perceptions of a partner's parenting ability motivated condom use.

Finally, experience of racism was unsurprisingly common considering participants are racially marginalised. However, the nature of racism experienced shifted from individualised and direct racism including the use of racial slurs, to institutional racism perpetrated by organisations that required frequent usage.

With poor sexual health outcomes amongst Black ethnic groups attributed to a complex interplay of individual and structural level cultural, socioeconomic and behavioural factors

(Public Health England, 2019a), the core role of institutional and structural racism in causing the socioeconomic causes of health inequalities must be acknowledged and used to increase understanding of racial and ethnic health inequalities (Marmot, 2018; Marmot & Wilkinson, 2005).

Experience of institutional racism created a lack of trust in services, whilst racist stereotypes regarding Black male sexuality created a fear of judgement when accessing sexual health services. Nevertheless, participants were still willing to engage with sexual health services when deemed necessary and usually prompted by symptoms of an STI. Experiences when accessed were positive and counteracted the mistrust underpinned by racism.

This study supports the emerging identification of trust as a determinant of health by highlighting the way experiences of institutional racism eroded participants' trust in health services, but also how positive experiences and professionalism when accessing sexual health services counteracts mistrust and promotes engagement.

Nationally, leading advisory bodies including BASHH, BHIVA and FRSH should promote the rebuilding of trust amongst Black ethnic groups in strategies and policies. Locally, sexual health services should actively focus efforts to repair trust and offer support to those who have been systemically underserved and marginalised with an aim to reducing inequality in healthcare access, experience and outcomes (Wadhawan et al., 2023).

Commissioners and service providers have often distanced themselves from those receiving services, enabling the sustainment of inequalities, and crafting conditions where racial and ethnic inequalities are accepted as the norm and something beyond the control of public health authorities (Nazroo et al., 2020). This study concludes by inviting commissioners and sexual health services to put an end to this by proactively learning how Black heterosexual men within their local community prefer to access services and build relationships with Black community organisations to facilitate service provision outside the clinical setting and encourage asymptomatic access.

6.0 References

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7.0 Appendices

7.1 Appendix A: Systematic review

Review article

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Are psychosocial interventions effective at increasing condom use among Black men? A systematic review

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Abstract

Black men experience a disproportionate burden of sexually transmitted infections (STIs) in the United Kingdom (UK). STIs can seriously affect the health and well-being of affected individuals. With condoms effective at preventing STI transmission, this review aims to explore the evidence of effectiveness of psychosocial interventions at increasing condom use among Black men to inform UK-based interventions for this at-risk but unheard population. Nine databases were searched for qualifying studies. Two reviewers independently assessed the quality of studies. A narrative synthesis read across the heterogeneous studies for evidence of effectiveness. A total of 17 studies met the inclusion criteria. This review identified scientifically weak evidence of effectiveness in multifaceted psychosocial interventions to increase condom use among Black men, particularly men who have sex with women and men who have sex with men mainly from United States settings. The multifaceted nature of interventions provides obscure evidence on successful elements of interventions with positive effects. Despite the disproportionate STI burden among this group, no UK-based studies were identified. Future research should aim to better understand condom use behavioural experiences and motivators of condom use among UK Black men to inform ethnically culturally relevant and tailored interventions.

Keywords

Condoms, psychosocial, interventions, Black

Introduction

Sexually transmitted infection (STI) rates remain a significant challenge in the United Kingdom (UK).[1] Since the 1980s, Black people have experienced a disproportionate burden of STIs in the UK[2,3] Recent data highlight this inequality, particularly among Black men, who have the highest rates of chlamydia, gonorrhoea and syphilis.[4]

Condoms remain the main protection against STIs yet barriers to use are reported.[5] Psychosocial, preventative, theory-informed behaviour-change interventions can be effective at increasing safer sex behaviours.[6,7]

Current review

This review aims to identify evidence of effective psychosocial interventions for condom use among Black men to provide evidence-based recommendations on effective approaches and techniques for practice with UK Black men. For this study, 'Black men' refers to cisgender men of Black ethnicity.

Psychosocial interventions vary in nature and include therapeutic counselling approaches and behaviour-change techniques including goal setting, action planning and exploration of barriers and facilitators of change.[8,9]

Methodology

This review was conducted as specified by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses protocol.[10]

A population, intervention, comparison and outcomes framework[11] underpinned the inclusion and exclusion criteria.

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7.2 Appendix B: Interview guide

Interview guide

- **Can you tell me a bit about yourself please**

Prompts could include age, relationship status, children, employment status and details, where were you born? Where did you grow up? School attended?

- **How long have you lived in London?**

Points to elaborate on include: were they born there? If not, when did they move there? Do they still live there? Have they lived anywhere else? How do you define yourself when asked where you're from and does this vary depending on who's asking? (e.g African/Caribbean to other Black people, British to White people?)

- **Can you tell me about your experience of growing up?**

Positives/challenges, did they experience financial challenges, did they live in a council estate or privately rented flat/house, what was the community like, family composition.

- **Where did you learn about sex and relationships?**

Points to elaborate on include: porn, school, parents, older siblings/cousins, friends, olders

- **What influence has being a Black man in London had on how you view sex and sexual relationships?**

Points to elaborate on include: is there a culture relating to sex/relationships that is promoted among Black men in London? Growing up, did anyone demonstrate behaviours that you idolised, valued or picked up on?

- **Growing up as a young Black man, are/were there certain sexual behaviours that are/were accepted or looked down upon (are/were depends on age)? Which of these behaviours do you currently do/not do?**

Prompts to elaborate on include: multiple partners, barebacking, giving/receiving head (use official terms and then ask what they refer to these behaviours as).

- **What is your experience of having more than one sexual partner?**

Points to elaborate on include: how would you define these partners (e.g bae, link etc)? what was your experience of using condoms within these partnerships? What were your reasons for using condoms with one but not others?

- **How does having more than one sexual partner make you feel and how does it make you look to peers?**

Points to elaborate on include: is there a sense of pride/guilt in having more than one partner? What influences pride/guilt? How do peers react upon discovery of multiple sexual partners? Do male/female peers react differently? How would parents/family react if they knew?

- **Team 'bareback' or 'strap up'? (use their preferred term)**

Points to elaborate on include: what does it mean to bareback? What are your reasons for barebacking/strapping up? does barebacking make you feel a sense of pride or guilt?

- **Research suggests that Black men report less condom use during sex. What goes through your mind when deciding whether or not to use condoms?**

Points to elaborate on include: If/when condoms are used, is your priority pregnancy prevention of STI prevention? Does this vary according to who you are having sex with? Can you give examples of who/when you would use condoms with and who/when you would not?

- **What does it mean to be a "real man"?**

Points to elaborate on: how does being a real man reflect sexual relationships, finances, family?

- **What does it mean to be a Black man?**

Points to elaborate on include: how does being a Black man affect the way you view sex/relationships? As a Black African/Caribbean man growing up in London, in what way did/does your views/perceptions on girls/women align with or contradict the views/perceptions of your culture/heritage?

- **Can you tell me about your experiences of racial discrimination?**

How have your experiences of racism affected how you view yourself as a man? How has racism affected your engagement with sexual health services? Do you feel like sexual health services are tailored to meet the needs of Black men? Why/why not, what could improve this?

- **Closing statements and debrief – opportunity for participants to ask questions, address any issues, and go over any points that were to be 'picked up later'.**

7.3 Appendix C: Recruitment poster

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ARE YOU A BLACK MAN WHO HAS SEX WITH ONLY WOMEN?

WOULD YOU BE WILLING TO TAKE PART IN A 1 HOUR CONFIDENTIAL VIRTUAL INTERVIEW DISCUSSING YOUR EXPERIENCES OF GROWING UP AND YOUR SEXUAL BEHAVIOURS, ATTITUDES AND MOTIVATORS?

YOUR TIME WILL BE COMPENSATED WITH A £30 HIGH-STREET SHOPS VOUCHER. YOU WILL RECEIVE DETAILS ON HOW TO CLAIM YOUR VOUCHER AT THE END OF YOUR INTERVIEW.

THIS RESEARCH IS BEING DONE AS A PARTIAL REQUIREMENT OF THE DEGREE OF PROFESSIONAL DOCTORATE IN HEALTH PSYCHOLOGY. THE RESEARCH HAS BEEN APPROVED BY THE FACULTY OF HEALTH AND APPLIED SCIENCES ETHICS COMMITTEE AT THE UNIVERSITY OF THE WEST OF ENGLAND (UWE) BRISTOL. ETHICS REFERENCE: HAS.20.05.178.

7.4 Appendix D: Participant information sheet

Participant Information Sheet

An exploration of the sexual health experiences and motivators of Black heterosexual men in London: A qualitative study.

You are invited to take part in a research study taking place at the University of the West of England, Bristol. The research is being conducted as part of the Professional Doctorate in Health Psychology degree.

Before you decide whether to take part, it is important for you to understand why the study is being done and what it will involve. Please read the following information carefully and if you have any queries or would like more information please contact:

Researcher: Mr Uzochi Nwaosu, Faculty of Health and Applied Sciences, University of the West of England, Bristol. Email: Uzochi2.Nwaosu@live.uwe.ac.uk.

Research supervisor (Director of Studies): Dr Jane Meyrick, Faculty of Health and Applied Sciences, University of the West of England, Bristol. Email: Jane.Meyrick@uwe.ac.uk.

What is the aim of the research?

We want to develop a better understanding of the psychological processes associated with sexual behaviours including, multiple sexual partners and condomless sex among Black heterosexual men in London. We also want to better understand how local peer culture on sexual attitudes, motivators and behaviours. It is hoped that the findings from this research will contribute to work being done to improve the sexual health of Black men and support to develop culturally appropriate sexual health services for Black men in the UK.

We want to know:

- What is it like to be a Black heterosexual man from London?
- What is it like living in London and how does this impact on how people have sex, their sexual relationships and what they think about this?
- What is the London Black heterosexual male experience of sexual partnerships and how does condom use in these partnerships vary?
- What motivates Black heterosexual men from London to use condoms during sex?
- In what way does the experience of racism impact on how Black heterosexual men from London engage with sexual health services?

To help us answer these questions I will be conducting completely anonymous and confidential interviews. You are not required to disclose your real name and are more than welcome to use a fake name. If you choose to use a fake name, it is important that you remember the details you

provided. The aim of the interviews will be to collect information that will be made anonymous. Common ideas shared will be put into a report for my doctoral thesis and made available on the University of the West of England's open-access repository. The anonymised results may also be used in conference papers and peer-reviewed academic papers. If you would like a copy of the report, please let me know at the end of your interview. You can also request a copy by emailing me at Uzochi2.Nwaosu@live.uwe.ac.uk.

Why have I been invited to take part?

As a sexually active Black heterosexual man, I am interested in hearing about your experience of growing up in London, your sexual behaviours, attitudes and motivators. The interview will therefore ask you about these things. The purpose of the questions will be to gain an understanding of your experience growing up in London and how you feel this has contributed to your sexual health behaviours, attitudes and motivators. I will not be asking questions about the identity of your sexual partners and you are under no obligation to answer any questions that you do not feel comfortable answering. Your interview will be anonymised, preventing you from being identified.

Do I have to take part?

You do not have to take part in this research. It is up to you to decide whether or not you want to be involved. If you decide to take part, you will be given a copy of this information sheet to keep and will be asked to sign a consent form. If you decide to take part, you can pull out from the research without giving a reason until the point that your interview is anonymised and can therefore no longer be traced back to you. This will be approximately 5 months from the date you sign the consent form. If you want to pull out from the study, please email Uzochi2.Nwaosu@live.uwe.ac.uk. Deciding not to take part or pull out from the study does not have any consequence.

What will happen to me if I take part and what do I have to do?

If you agree to take part you will be initially contacted via telephone call by the researcher to confirm eligibility, confirm consent, provide you with a participant number and schedule either a 1:1 telephone interview or video interview at a time convenient for you. Video interviews will be conducted through Skype, Facetime or WhatsApp video call. You will be asked to indicate your preferred interview method and provide relevant contact details. The interview will last approximately 1 hour.

The subject and focus of the discussion will be your experience of growing up in London and your sexual behaviours, attitudes and motivators. Your answers will be fully anonymised.

Your interview will be audio recorded on a voice recorder but the recording will not contain your name. Only my research supervisor and I will hear your audio recorded interview.

Your participant number will be used to re-identify you if you choose to pull out from the study within the withdrawal period, up to 5 months after the date you signed the consent form. At the point of transcribing interviews, your voice recording will be deleted. Your data will be anonymised at this point and will be analysed with interview data from other anonymised participants.

Any data you provide will be stored securely and managed in line with Data Protection legislation.

What are the benefits of taking part?

Your participation will contribute gaining the required understanding to be able to develop culturally relevant and appropriate sexual health interventions for Black heterosexual men in the UK.

Your time will be compensated with a free haircut/shape-up to the value of £20 at the barbershop you were recruited from. You will receive details on how to access your free haircut/shapeup at the end of your interview.

What are the possible risks of taking part?

I do not foresee or anticipate any risk to you in taking part in this study. If, however, you feel uncomfortable at any time you can ask for the interview to stop. If you need any support during or after the interview then I will be able to put you in touch with suitable support agencies. I am an experienced sexual health practitioner and sensitive to the subject area.

What will happen to your information?

All the information we receive from you will be treated in the strictest confidence.

All the information that you give will be kept confidential and anonymised approximately 5 months from the date of your signed consent form. The only circumstance where we may not be able to keep you information confidential is if you disclose something during the interview that makes me believe that either you or somebody else could be at risk of imminent harm. I will make this clear at the time.

You will be allocated a participant number to protect your anonymity. Research material with identifiable information will be stored in a locked, password protected and secure setting to which only the researchers will have access in accordance with the University and Data Protection Act 2018 requirements.

Voice recordings of the interviews may be passed to a transcription company or contractor to convert interview audio to text. Only companies with a formal data processing agreement with the university will be considered.

Voice recordings will be destroyed securely immediately after anonymised transcription. Your anonymised data will be analysed together with other interview and file data, and we will ensure that there is no possibility of identification or re-identification from this point.

Where will the results of the research study be published?

A report will be written containing the research findings. This report will be available on the University of the West of England's open-access research repository. The report will also be submitted for publication in peer-reviewed academic journals. A hard copy of the report will be made available to all research participants if you would like to see it.

Key findings will also be shared both within and outside the University of the West of England at various conferences. Anonymous and non-identifying direct quotes may be used for publication and presentation purposes.

Who has ethically approved this research?

The project has been reviewed and approved by the Faculty of Health and Applied Sciences Research Ethics Committee. Any comments, questions or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at Researchethics@uwe.ac.uk.

What if something goes wrong?

Should you have any concerns, queries or complaints, please contact my Director of Studies, Dr Jane Meyrick at Jane.Meyrick@uwe.ac.uk.

What if I have more questions or do not understand something?

If you would like any further information about the research please contact me in the first instance at Uzochi2.Nwaosu@live.uwe.ac.uk.

Thank you for agreeing to take part in this study. You will be given a copy of this Participant Information Sheet and your signed Consent Form to keep.

7.5 Appendix E: Study privacy notice

Research Privacy Notice for Research Participants

Purpose of the Privacy Notice

This privacy notice explains how the University of the West of England, Bristol (UWE) collects, manages and uses your personal data before, during and after you participate in the research study titled "An exploration of the sexual health experiences and motivators of Black heterosexual men in London: A qualitative study". 'Personal data' means any information relating to an identified or identifiable natural person (the data subject). An 'identifiable natural person' is one who can be identified, directly or indirectly, including by reference to an identifier such as a name, an identification number, location data, an online identifier, or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.

This privacy notice adheres to the General Data Protection Regulation (GDPR) principle of transparency. This means it gives information about:

- How and why your data will be used for the research;
- What your rights are under GDPR; and
- How to contact UWE Bristol and the project lead in relation to questions, concerns or exercising your rights regarding the use of your personal data.

This Privacy Notice should be read in conjunction with the Participant Information Sheet and Consent Form provided to you before you agree to take part in the research.

Why are we processing your personal data?

UWE Bristol undertakes research under its public function to provide research for the benefit of society. As a data controller we are committed to protecting the privacy and security of your personal data in accordance with the (EU) 2016/679 the General Data Protection Regulation (GDPR), the Data Protection Act 2018 (or any successor legislation) and any other legislation directly relating to privacy laws that apply (together "the Data Protection Legislation"). General information on Data Protection law is available from the Information Commissioner's Office (https://ico.org.uk/).

How do we use your personal data?

We use your personal data for research with appropriate safeguards in place on the lawful bases of fulfilling tasks in the public interest, and for archiving purposes in the public interest, for scientific or historical research purposes.

We will always tell you about the information we wish to collect from you and how we will use it. We will not use your personal data for automated decision making about you or for profiling purposes.

Our research is governed by robust policies and procedures and, where human participants are involved, is subject to ethical approval from either UWE Bristol's Faculty or University Research Ethics Committees. This research has been approved by Faculty of Health and Applied Sciences Research Ethics Committee. The ethics application reference number is ***(to be added once obtained)***. Any comments, questions or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at Researchethics@uwe.ac.uk. The research team adhere to the **Ethical guidelines of the British Educational Research Association (and/or the principles of the Declaration of Helsinki, 2013) and the principles of the General Data Protection Regulation (GDPR).**

For more information about UWE Bristol's research ethics approval process please see our Research Ethics webpages at:

www1.uwe.ac.uk/research/researchethics

What data do we collect?

The data we collect will vary from project to project. Researchers will only collect data that is essential for their project. The specific categories of personal data processed are described in the Participant Information Sheet provided to you with this Privacy Notice.

Who do we share your data with?

We will only share your personal data in accordance with the attached Participant Information Sheet and your Consent.

How do we keep your data secure?

We take a robust approach to protecting your information with secure electronic and physical storage areas for research data with controlled access. If you are participating in a particularly sensitive project UWE Bristol puts into place additional layers of security. UWE Bristol has Cyber Essentials information security certification.

Alongside these technical measures there are comprehensive and effective policies and processes in place to ensure that users and administrators of information are aware of their obligations and responsibilities for the data they have access to. By default, people are only granted access to the

information they require to perform their duties. Mandatory data protection and information security training is provided to staff and expert advice available if needed.

How long do we keep your data for?

Your personal data will only be retained for as long as is necessary to fulfil the cited purpose of the research. The length of time we keep your personal data will depend on several factors including the significance of the data, funder requirements, and the nature of the study. Specific details are provided in the attached Participant Information Sheet. Anonymised data that falls outside the scope of data protection legislation as it contains no identifying or identifiable information may be stored in UWE Bristol's research data archive or another carefully selected appropriate data archive.

Your Rights and how to exercise them

Under the Data Protection legislation you have the following **qualified** rights:

(1) The right to access your personal data held by or on behalf of the University;
(2) The right to rectification if the information is inaccurate or incomplete;
(3) The right to restrict processing and/or erasure of your personal data;
(4) The right to data portability;
(5) The right to object to processing;
(6) The right to object to automated decision making and profiling;
(7) The right to complain to the Information Commissioner's Office (ICO).

Please note, however, that some of these rights do not apply when the data is being used for research purposes if appropriate safeguards have been put in place.

We will always respond to concerns or queries you may have. If you wish to exercise your rights or have any other general data protection queries, please contact UWE Bristol's Data Protection Officer (dataprotection@uwe.ac.uk).

If you have any complaints or queries relating to the research in which you are taking part please contact either the research project lead, whose details are in the attached Participant Information Sheet, UWE Bristol's Research Ethics Committees (researchethics@uwe.ac.uk) or UWE Bristol's research governance manager (Ros.Rouse@uwe.ac.uk)

v.1: This Privacy Notice was issued in April 2019 and will be subject to regular review/update.

7.6 Appendix F: Study consent form

Participant Consent Form

Project title: An exploration of the sexual health experiences and motivators of Black heterosexual men in London: A qualitative study

This consent form will have been given to you with the Participant Information Sheet. Please ensure that you have read and understood the information contained in the Participant Information Sheet and asked any questions before you sign this form. If you have any questions please contact a member of the research team, whose details are set out on the Participant Information Sheet.

If you are happy to take part in video interviews via Skype, Facetime or WhatsApp, please sign and date the form. You will be given a copy to keep for your records.

By signing this form, you indicate the following:

- I have read and understood the information in the Participant Information Sheet which I have been given to read before asked to sign this form;
- I have been given the opportunity to ask questions about the study;
- I have had my questions answered satisfactorily by the research team;
- I agree to my interview recording being shared with a UWE approved transcription service;
- I agree that anonymised quotes may be used in the final Report of this study;
- I understand that my participation is voluntary and that I am free to withdraw at any time until the data has been anonymised, without giving a reason;
- I agree to take part in the research

Name (Printed)…….

Signature……. Date…….

7.7 Appendix G: Initially generated codes

Name	Description
A real man	Use this when ppnts discuss what they feel makes someone a real man
Absent fathers	Use this when ppnts discuss the impact of absent fathers on children or the community
Acceptable sexual behaviours	Use this when ppnts discuss sexual behaviours that are generally deemed as acceptable or promoted among London Black men
Actions - sexual health services - Black men	Use this when ppnts discuss how they feel sexual health services can better meet the needs of Black men
Actions of a real man - sex and r'ships	Use this when ppnts discuss what a real man does in relation to sex and r'ships
Actions or behaviours of a real man - general	Use this when ppnts discuss what they feel a real man does generally or day to day
Alone or as a group - sexual health services	Use this when ppnts discuss who they attended a sexual health clinic with and why
anti condom use	Use this when ppnts discuss reasons against condom use
Area of residence	Use this code when ppnt's mention their area of residence.
Baby mother character traits	Use this when ppnts discuss traits that they want or do not want in someone who would be the mother of their child/ren
Being a Black man	Use this when ppnts discuss what they feel it means to be a Black man
Being a role model	Use this when ppnts discuss their responsibility or actions they engage in to set a good example to the next generation
Black mens sexual health needs	Use this when ppnts discuss what they feel the sexual health needs of Black men are
Challenges of being a Black man	Use this when ppnts discuss the challenges associated with being a Black man
Condom use experiences	Use this when ppnts discuss striking experiences of condom use - positive or negative
Condom use perceptions	Use this when ppnts discuss how they or Black males perceive condom use
Condomless sex influences	Use this when ppnts discuss factors that would influence them to not use a condom

Name	Description
Condomless sex meaning	Use this when ppnts discuss meaning attached condomless sex
Culture or heritage sexual norms	Use this when ppnts discuss sexual norms associated with their culture or heritage
Current - sexual health services - Black men needs	Use this when ppnts discuss whether they feel the needs of Black men are met by sexual health services
Current day-to-day activities	Use this everytime ppnt describes what they do for a living.
Dating expectations	Use this when ppnts discuss what is expected of them whilst dating or involved in sexual r'ships
Dating or seeing Black women	Use this when ppnts discuss their experiences or perceptions of being in a r'ship with a Black woman
Decisions behind main vs side ting	Use this when ppnts discuss their rationale for assigning main vs side title to girls
Differences in SRE - educators	Use this when ppnts discuss the differences in SRE received depending on who receiving from
Discussing experiences of racism	Use this when ppnts discuss their experiences or perceptions of discussing racism with others
Ego	Use this when ppnts discuss things that feeds their ego
Enquirer demographic on identity	Use this code when ppnts describe how they respond to enquiries on identity depending on the demographic of the enquirer
Expectations during sex	Use this when ppnts discuss how they/men are/were expected to behave during sex or sexual encounters.
Experience of multiple sexual partners	Use this when ppnts discuss their experience of having multiple sexual partners
Experience of using sexual health services	Use this when ppnts discuss their experiences of using sexual health services
Experiences of condom use within multiple partnerships	Use this when ppnts discuss their experiences of using condoms when they have concurrent partnerships.
Experiences of racial sexual stereotypes	Use this when ppnts discuss their experiences of racial sexual stereotypes and what impact these have or how they feel about these
Experiences of racism	Use this when ppts describe their experiences of perceived racism

Name	Description
External perceptions of having multiple partners	Use this when ppnts discuss how they are viewed by others for having multiple sexual partners
Family structure	Use this when ppnts mention their family make-up
Fatherhood	Use this when ppnts discuss how fatherhood impacts their behaviour, attitudes, perceptions
Feelings after condomless sex	Use this when ppnts discuss their feelings after condomless sex
Feelings during a pregnancy scare or confirmed pregnancy	Use this when ppnts discuss their feelings when informed by a girl or woman that they suspect they are pregnant or confirm that they are pregnant
Feelings when accessing sexual health services	Use this when ppnts discuss how they felt as they accessed sexual health services.
First exposure to SRE	Use this when ppnts mention their first experience of SRE
Generational divide	Use this when ppnts discuss generational differences in views and perceptions on sex and r'ships
Getting lots of girls	Use this when ppnts discuss positive attitudes, beliefs or behvaiours related to having lots of girls among Black men in LDN
Girls influencing guys	Use this when ppnts discuss how girls' behaviour influences their attitudes, perceptions of behaviours in terms of sex and r'ships
Growing up	Use this when ppnts discuss experiences of growing up
Growing up - education	Use this when ppnts discuss their experiences of engaging with school
Hood life	Use this when ppnts discuss their experiences of growing up in the hood
Identity in the work setting	Use this when ppnts discuss how they disclose or express their identity in a work environment
Image and girls	Use this when ppnts discuss how image affects how girls perceive men and behave around them
Image and males	Use this when ppnts discuss how certain behaviours make them look amongst other males
Immigration	Use this code when ppnt's mention immigration of parents
Impact of LDN on sex and r'ships	Use this when ppnts discuss how living in London affects their sexual and r'ship behaviours or attitudes

Name	Description
Impact of porn	Use this when ppnts discuss how porn has impacted their sexual and relationship behaviours or perceptions - whether positive or negative
Impact of race on life	Use this code when ppnts talk about the impact of race on the life or daily activities of Black men
Impact of racism on life	Use this when ppnts discuss how their experiences of racism has affected how they go about their life now
Interactions with authorities	Use this when ppnts discuss their dealings with authorities whether positive or negative
Interracial sexual relationships	Use this when ppnts discuss origins or dynamics of interracial sexual r'ships - including how this made them feel
London Black male views on sex r'ships	Use this when ppnts discuss how Black men in London view sex and r'ships
London vs heritage - views on girls	Use this when ppnts discuss similarities or differences in their views on girls/women vs the views of their culture/heritage
Maturity	Use this when ppnts discuss how ageing and maturity influences their perceptions and attitude towards sexual behaviours, having multiple partners or condom use
National identity	Use this code when ppnts describe their nationality
Not boasting	Use this when ppnts discuss not boasting to friends about sex or women
Origins of perceptions of a real man	Use this when ppnts discuss where their perceptions of a real man originate from
Parental r'ship	Use this when ppnts describe the r'ship between their parents
Peer norms - London Black men	Use this when ppnts discuss accepted beliefs or behaviors among Black men in London
Peer pressure when young	Use this when ppnts discuss experiencs of direct or indirect pressure from peers to engage in sexual acts
Perceptions of Black British culture	Use this when ppnts discuss their perceptions of Black British culture
Perceptions of British culture	Use this when ppnts discuss how they perceive British culture
Perceptions of cultural heritage	Use this when ppnts discuss their perceptions of their cultural heritage

Name	Description
Perceptions of girls	Use this when ppnts discuss perceptions on girls' behaviours
Perceptions of growing up today	Use this when ppnts describe their perceptions of what life is like for children growing up today.
Perceptions of multiple sexual partners	Use this when ppnts discuss how they feel about multiple sexual partners
Perceptions of sex	Use this when ppnts discuss their perceptions on sexual acts or meaning attached to sex
Perceptions on being a good parent	Use this when ppnts discuss what they feel makes a good parent
Porn - fantasy vs reality	Use this when ppnts discuss if/when and how they came to the realisation of the scripted nature of porn.
Positive r'ships with Black males	Use this when ppnts discuss positive r'ship with Black men in their life or role models.
Positives of being a Black man	Use this when ppnts discuss the positives associated with being a Black man
Poverty and sex	Use this when ppnts discuss how poverty impacts sexual behaviours
pro condom use	Use this when ppnts discuss reasons behind their condom use
Race relations	Use this when ppnts discuss factors that have affected race relations
Racism and engaging with health services	Use this when ppnts discuss how their experiences of race influences how they engage with health services
Rating of SRE	Use this when ppnts describe how they would rate their experience of SRE
Reasons for using sexual health services	Use this when ppnts discuss their reasons for accessing sexual health services
Relationship status	Use this everytime a ppnt describes their current r'ship status
R'ship meaning	Use this code everytime a ppnt describes the meaning of their r'ship status
SES	Use this everytime a ppnt describes their SES
SES meaning	Use this code when ppnts define what their SES means to them
Sexual debut	Use this when ppnts discuss their sexual debut - age or experience

Name	Description
Sexual performance	Use this when ppnts discuss their expectations to perform or what performing during sex means to them
social class benefits	Use this when ppnts discuss perceived benefits of higher social class
Social influences on views on sex and relationships	Use this when ppnts discuss social factors that influence perceptions on sex and r'ships.
SRE content	Use this when ppnts discuss information obtained from educational sources despite the source
SRE from family	Use this when ppnts mention their experience of discussing sex and relationships with family - including if unable to
SRE source	Use this when ppnts discuss where they learned about sex and relationships
STI experience	Use this when ppnts discuss their experience of an STI - whether diagnosed or symptomatic
STI vs pregnancy preventions	Use this when ppnts discuss and compare motivations for condom use
Taboo	Use this when ppnts discuss a taboo surrounding sex, r'ships or sexual health
Talking about sex	Use this when ppnts discuss conversations about sex
The community	Use this when ppnts discuss the impact of the community when growing up
Treatment towards girls	Use this when ppnts discuss how they believe women or girls should be treated
Typology of sexual partners or behaviours	Use this when ppnts discuss how they define the each person when they have multiple partnerships or how they define certain sexual behaviours
Unacceptable sexual behaviours	Use this when ppnts discuss sexual behaviours that are generally deemed as unacceptable among London Black men
Unvalued observed sexual behaviours	Use this when ppnts describe sexual behaviours that they have observed but dismissed, did not value or agree with
Valued observed behaviours	Use this when ppnts discuss observed sex and r'ship behaviours that they valued or rated.

7.8 Appendix H: Refined codes

Name	Description
FOR MY INFO - differences between main and non-main partners	Use this when ppnts discuss differences between main and non-main partners
FOR MY INFO - Typology of sexual partners or behaviours	Use this when ppnts discuss how they define the each person when they have multiple partnerships or how they define certain sexual behaviours
N - a real man demonstrates responsibility for the physical and social wellbeing of their family and holds themselves accountable	Use this when ppnts discuss a real man having responsibility and accountability to their loved one's.
N - a real man doesn't feel emasculated when unable to fulfill some social gender stereotypes. Rather you should focus on being the best version of yourself	
N - a real man knows his strengths and weaknesses thus is able to recognise and accept when they may not be the best person to take charge of a certain situation	Being a real man does not always require leadership. Being a real man means being able to acknowledge that you may not be the best leader so you let the partner lead
N - a real man steps up to the responsibilities and consequences associated with condomless sex rather than abandoning their responsibilities in the case of a sexual partner becoming pregnant	Use this when ppnts discuss stepping up to responsibilities of UPSI - e.g. pregnancy
N - a real man values the source of his money over the amount of money being made.	Use this when ppnts discuss how a real man makes money legitimately rather than through illegal activities
N - advancements in technology have contributed to the generational division in the way current generation and parent's generation	Use this when ppnts discuss how developments in technology have changed how relationships are formed and progress when compared to how their parent's generation navigated relationships

Name	Description
viewed and engaged in sex and relationships	
N - an inability to live up to sexual expectations can negatively affect Black men psychologically	Use this when ppnts discuss the psychological impact of not being able to live up to sexual expectations
N - anal sex or foreplay is perceived negatively and avoided largely due to it's association with homosexual sexual activities which was largely shunned upon.	Use this when ppnts discuss a negative perception towards anal sexual activities because of it's close association with homosexual sexual acts which were generally shunned upon
N - as you get older, it becomes more acceptable to have just one partner that you settle and build with	Use this when ppnts discuss how perceptions to having multiple partners change as they age
N - association of hard work and grafting with being working class as opposed to the perception of a more comfortable life associated with middle and upper classes	Use this when ppnts discuss associating with working class identity because of their experiences of hard work and grafting
N - behaviours that are associated with high social status makes one feel superior to other men	Status associated with appearing to have money, women and materialistic possessions make men feel more superior than men who do not appear to possess these things. However, whilst this feeds ego, it is not the same as feeling more of a man than the other men.
N - Being a Black man comes with additional responsibility to protect family from racism	Use this when ppnts discuss the responsibility for Black men to help family deal with racism
N - being a Black man means accepting there are extra hurdles in life and working harder to navigate these rather than just complaining about them	
N - Being a Black man means having to go the extra mile	Use this when ppnts discuss Black men having to work harder than their counterparts of other races
N - being a Black man requires a demonstration of mental strength and no vulnerability	Use this when ppnts discuss the need for Black men to show strength or hide vulnerabilities

Name	Description
N - Being a father results in increased maturity that makes men value relationships with the mother of a child more	Use this when ppnts discuss increased maturity as a result of fatherhood which results in them valuing the r'ship with their child's mother more
N - Being a father to a girl increases empathy towards women and makes men more conscious of the unwanted sexual advances and harrassment many women experience	Use this when ppnts discuss how being a father to a girl results in them developing a greater sense of awareness to some of the issues women experience daily and empathise more as they do not want to imagine their daughter experiencing these things.
N - being a real man has little to do with the size of your wallet	Being a real man entails more than how much money you have or can provide. You can be a real man with little to no money
N - being a real man has nothing to do with physical strength	Being a real man entails more than physical strength - more about responsibilities
N - being an immigrant automatically places you into a working class category because you will have to demonstrate workng class attributes like hard working and grafting to be able to provide for your family and survive	Use this when ppnts discuss an being working class because either them, their parents or grandparents migrated to the UK, almost pushing them into a working class structure
N - being around older and more experienced siblings, cousins and friends comes with exposure to sexual content including conversations, ideologies and behaviours	Use this when ppnts discuss being exposed to sexual content whilst around older siblngs, cousins and friends
N - being around older family or olders on the estate exposes you to conversations about sex and relationships from a really young age	Use this when ppnts discuss being exposed to conversations and content about sex and relationships from a young age because of their association with older family or peers
N - being asymptomatic can result in false sense of security because of a lack of awareness around the	Use this when ppnts discuss feeling confident they do not have an STI because they do not have any symptoms

Name	Description
asymptomatic nature of many STIs	
N - being Black does not really influence sexual relationships when young. You just want to be like your friends and go along with what is deemed as the norm regardless of race	
N - Being seen by a Black staff member in a SH clinic may result in embarrassment	Use this when ppnts discuss the embarrassment experienced when being seen by Black staff at sexual heath services.
N - Black male bodies are sexualised by non-Black women which results in Black men engaing in sexual encounters that they may not necessarily want to engage in.	Use this when ppnts discuss being sexualised by White women and White women expressing sexual interest in them because of their blackness as opposed to because of a genuine interest in them as a person
N - Black male sexual stereotypes prevent Black men from seeking support for sexual health issues.	Use this when ppnts discuss how historic sexual stereotypes about Black men prevent them from seeking support for sexual health issues.
N - Black men are expected to be dominant during sex thus should not be engaging in passive behaviours like performing oral sex	
N - Black men are happy to engage in SI with non-Black women but plan to settle down with a Black woman	Use this when ppnts discuss aim to settle down with Black women
N - Black men don't use condoms as society does not care about Black men	Use this when ppnts discuss the feeling that Black men have stopped caring about themselves as nobody in society cares about them thus they don't care about UPSI consequences
N - Black men feel pressure to live up to sexual expectations society has placed on them	Use this when ppnts discuss Black men engaging in sexual acts or behaviours because of the sexual expectation that has been placed on the via stereotypes
N - Black men have sexual expectations placed on them underpinned by racist stereotypes	Use this when ppnts discuss expectations placed on them as a result of racist sexual stereotypes

Name	Description
N - Black men in London have differing attitudes towards performing oral sex vs Black men in America as a result of the Caribbean influence on London Black male sexual attitudes	
N - Black men in London perceive exclusive relationships as something that should occur at a later age whilsts being young is for having sexual fun	Use this when ppnts discuss the perception that youth should be used for exploring casual sexual relationships rather than setting down in an exclusive r'ship
N - Black men were more likely to engage in interracial relationships than Black women	Use this when ppnts discuss the commonality of interracial relationships involving Black men but less common among Black women
N - Black people embrace nature and prefer things to feel more natural thus condoms are disliked among Black men	Use this when ppnts discuss dislikin condoms because of the perception it is artificial or not natural. This is compared to using natural products when unwell vs taking meds
N - by failing to target Black men, sexual health services are neglecting the sexual health needs of Black men	Use this when ppnts discuss a negect of Black men's needs by sexual health services.
N - condomless sex demonstrates a perception of seriousness in the r'ship on behalf of the man	Use this when ppnts discuss condomless sex as demonstrating that things are serious between them and their partner
N - condomless sex demonstrates value over other partners and represents trust in a partner	Use this when ppnts discuss engaging in condomless sex as a way of demonstrating to their partners that they value them over other women and trust them
N - condomless sex is a symbol of exclusivity with a sexual partner	Use this when ppnts discuss using condomless sex as a symbol of sex with solely one person
N - condoms are awkward to use which can result in the whole sexual encounter becoming awkward	Use this when ppnts discuss a feeling of awkwardness associated with condom use

Name	Description
N - condoms are embraced more as you get older as it becomes more important to protect yourself from health conditions and take precautions	Use this when ppnts discuss using condoms as they age because of a greater sense of needing to protect themselves as they get older
N - condoms are inconvenient and becomes something else you have to do or remember rather than just going with the flow	Use this when ppnts discuss inconvenience associated with condom use
N - condoms are used if it is suspected that the woman is having sex with other men	Use this when ppnts discuss using condoms because they suspect or are aware that their partner is having sex with other men, and not used as they felt confident that the woman was only having sex with them
N - condoms are used or not used based on the outcome of an assessment on the woman, including perceptions about the woman	Use this when ppnts discuss condom use behaviours based on the perception of the woman. Perception can be influenced by various factors including where the woman was met, their physical appearance, their demeanour and personality.
N - condoms are used primarily to prevent STI acquisition as an abortion can be used to terminate a pregnancy in the worst-case scenario.	Use this when ppnts discuss using condoms to mainly prevent STIs because abortions can be used to terminate a pregnancy
N - condoms are used to prevent acquiring an STI thus prevent being caught cheating on a main partner	Use this when ppnts discuss using condoms during concurrent partnerships to prevent being caught cheating as condoms reduce their chances of contracting an STI
N - condoms are used with non-main partners but UPSI generally occurs with main partners. Main partner does not always mean someone you are in a monogamous relationship with however.	Use this when ppnts discuss using condoms with non-main partners with UPSI with main partner
N - condoms can negativey impact sexual performance including being able to achieve and sustain an erection and delayed ejaculation	Use this when ppnts discuss feeling that condom use negatively impacts their sexual performance

Name	Description
N - condoms make sex less pleasurable and can make the experience feel artificial and less wholesome.	Use this when ppnts discuss a loss of pleasure when using condoms
N - cultural heritage viewed sex as a taboo thus talking about sex did not happen until you reach a certain age, or when your parents expect grandchildren	Use this when ppnts discuss not talking to parents about sex because of taboo but then parents expecting grandchildren when mid-20's
N - culture does not accept openly talking about sex as it is a heavily stigmatised topic	Use this when ppnts discuss their culture/heritage not supporting discussing topics like sex openly.
N - despite being born in the UK, the treatment received here, rejection from public and imbalance in privileges results in a reluctance to identify as British and view the UK as home	Use this when ppnts discuss not identifying as, or feeling British as a result of the lack of priviliges they are afforded or because of how they are treated in the UK
N - embarrassment associated with an STI diagnosis serves as a motivator for condom use. STI diagnosis tells others that you are not a cautious, careful or hygeinic individual	
N - even when a parent, conversations with children about sex and relationships focuses on condom use to prevent STI or pregnancy	Use this when ppnts discuss talking with their children about the importance of using condoms
N - exclusivity, familiarity or trust with sexual partners are pre-requisites for condomless sex	Use this when ppnts discuss perceiving their partner is exclusive to them or knowing them for a long time thus trusting them for UPSI to happen
N - experiences of engaging with sexual health services have been positive, professional and met needs.	Use this when ppnts discuss positivity about sexual health services or positive experiences
N - experiences of racism are, more often that not, perpetrated by institutions	Use this when ppnts discuss experiences of racism perpetrated by institutions and organisations as opposed to by individuals

Name	Description
and organisations rather than by individuals	
N - experiences of racism creates mistrust in medical professionals and fear of being misdiagnosed with conditions	Use this when ppnts discuss their mistrust in medical professionals as a result of their experiences of racism
N - experiences of racism results in mistrust in medical professionals and a fear of being intentionally misdiagnosed of falsely diagnosed and treated	Use this when ppnts discuss not trusting medical professionals because their experiences of racism have reduced trust, or the mistreatment of loved one's has resulted in suspicion in medical professionals
N - explicit lyrical content in rap music provides an initial introduction and awareness to the sexual anatomical features of womens bodies, albeit in an informal manner and informal terms used to describe features	Use this when ppnts discuss how rap music introduces them to certain parts of women's bodies that they were not initially aware of
N - fathers need to talk to their sons about sex and r'ships	Use this when ppnts discuss a need for fathers to talk to their sons about sex and r'ships. Also, the convo may be more meaningful coming from a father to son rather than a mother to son
N - fathers, uncles and older brothers can be influencial in the development of perceptions about what a real is is, says and does	Use this when ppnts discuss the influencial role of their father and older brothers in their perceptions about what a real man is
N - feeling of embarrassment when accessing sexual health services largely because of a fear of judgement from other service users as opposed to staff	Use this when ppnts discuss feeling embarrassed when accessing sexual health services
N - feelings of anxiety or worry after unplanned condomless sex is often relieved on receipt of a negative STI test result	Use this when ppnts discuss feeling worried after condomless SI because of the possibility they have acquired an STI

Name	Description
N - feelings of unpreparedness for parenthood and the lifelong implications of pregnancy on both them and the child motivates condom use to prevent pregnancy	Use this when ppnts discuss using condoms to prevent pregnancy because they do not feel ready to have a child thus pregnancy can have serious lifelong implications on both them and the child
N - forcing or pressuring girls and women into sexual activity is perceived as unaaceptable and demonstrates that the only way that someone can engage in sex is via non-consensual practices	
N - friends usually initiate initial conversations around sex and relationships but these conversations do not consider the understanding of participants and usually mock those with limited experience and little understanding	
N - general feeling of embarrassment when sexual content came on TV in front of parents. Parents also received the display of sexual activity on TV negatively	
N - getting older makes your acknowledge and apprecaite the risks associated with having multiple partners	Use this when ppnts discuss how their perception of risk associated with having multiple partners changes as they age
N - girls and women are drawn to materialistic things like money, cars and fame which means those with more of these things are more likely to succeed in having more girls or women	Use this when ppnts discuss how materialistic things like money, fame and cars influeces how girls and women behave towards them
N - growing up and living in London influences sexual behaviours as you're exposed to more sexually liberated girls and women thus more	Use this when ppnts discuss the sexual freeness of girls and women in London and how this influences their sexual behvaiours

Name	Description
likely to have sexual encounters	
N - growing up in London encourages the early onset of sexual activity	Use this when ppnts discuss their perception that growing up in London resulted in them having sex earlier than they would have had they grew up outside of London
N - growing up in London involves a culture amongst peers where you are all striving to demonstrate success by being the guy with the most girls, best trainers and strongest	
N - growing up, parents prioritised preventing their daughters getting pregnant whilst neglecting the need to speak with son's about sex and contraception	
N - growing up, the olders displayed a level of confidence when talking to girls and women that was acknowledged by the youngers and impressed the girls and women they were talking to	Use this when ppnts discuss observing their olders display a level of confidence when talking to girls/women which often impressed the girls/women and showed the youngers what they needed to display to achieve a similar level of success
N - having lots of partners is not manly or something to be proud about	Use this when ppnts discuss negative perceptions of having multple partners
N - having multiple partners comes with different positive sexual and non-sexual experiences as each woman will bring something different to the encounter which is valued over the same experiences with one woman	Use this when ppnts discuss the different experiences associated with having multiple partners
N - having multiple partners is accepted among males of all ethnicities but Black YP were the one's who were most likely to boast about it	Use this when ppnts discuss the acceptance of multiple partners amongst all young men but only Black YP boasting about it.

Name	Description
N - having multiple partners is normalised among peers as you age so nothing to boast about	Use this when ppnts discuss the normalisation and acceptance of having multiple partners as they age so not something to boast about, in contrast to when young
N - having multiple partners is unwritten, but accepted from young	Use this when ppnts discuss an acceptance to having multiple partners which originated as a young person
N - having multiple partners seems to be an unwritten norm as opposed to something that is pubicly promoted and encouraged	Use this when ppnts discuss the norm of having multple partners, particularly the unspoken yet normalised and accepted manner
N - having multiple partners was accepted as the norm and was commonly accepted among women too thus would not turn them away	Use this when ppnts refer to a normalisation in having multiple partners
N - having multple partners occurs opportunistically as opposed to planned	Use this when ppnts discuss the opportunistic nature of concurrent partnerships rather than the planned seeking of extra partners
N - health services, including SH services are designed around the needs of the doctors who work in them, and who are predominantly white men	Use this when ppnts discuss their perception that SH services are designed to meet the needs of the white male doctors staffing them
N - hearing about friends engaging in sexual experiences makes you inquisitive and want to do what your friends have been doing	Use this when ppnts discuss wanting to engage in sexual behaviours as a result of wanting to replicate their friend's behaviours
N - heritage is surpressed in a professional and official contexts whilst proximity to Britishness is emphasised	Use this when ppnts discuss the need to identify as British as opposed to Afrrican/Caribbean when engaged in official or professional activities.
N - higher perceived severity towards HIV than bacterial infections can result in the primary focus of condom use being for HIV prevention	Use this when ppnts discuss perceiving bacterial infections as less serious as they are easily treated with antibiotics thus condoms are used solely to prevent HIV acquisition. Important in the context of freely available PEP/PrEP for HIV prevention

Name	Description
rather than general STI prevention	
N - HIV pandemic changed the societal opinion on talking about sex due to people dying from a preventable infection largely acquired during sex.	Use this when ppnts discuss how public conversations around sex were initiated because of the very real threat from the HIV pandemic
N - Jamaican culture very dismisive of men performing oral sex and this has had an influence on Black men in London through engaging with Jamaican culture and music	Use this when ppnts discuss the impact of Jamaican culture and music on how Black men perceive performing oral sex on women
N - lifetime commitment to a woman you do not anticipate successfully co-parenting with or getting along with motivates condom use to prevent pregnancy	Use this when ppnts discuss using condoms to prevent pregnancy because they do not feel they will get along with the woman who would subsequently be the mother of their child for life
N - living in London enables Black men to integrate freely with women as the diverse nature of the city removes the race barrier that would prevent non-Black women from engaging with them as would happen outside of LDN where there are less Black people	
N - living in London provides access to a wider variety of women which makes it easier to engage in sexual encounters	Use this when ppnts discuss their perception that living in London increases accessibilty to a wide range of women which ultimately increases the chances of engaging in sexual acts
N - low perceived susceptibility to the consequences of condomless sex can be a major influence in not using condoms	Use this when ppnts discuss low perceived susceptibility to a lack of condom use
N - loyalty to identifyng as working-class is influenced by the unforgettable experience	

Name	Description
and understanding of growing up in poverty	
N - males performing oral sex is unacceptable when young but becomes more acceptable as one becomes more sexually and emotionally mature	Use this when ppnts discuss the unacceptable perception of performing oral sex when young, but become more open to it as they get older and more mature. However, the taboo makes it difficult to openly admit to performing oral sex
N - media content from rap and porn shape initial ideas about how girls and women should be treated	Use this when ppnts discuss initially generating ideas about what to do/say to women and girls from media content like porn and rap music
N - more meaningful conversations about sex and relationship occurs with brothers, particularly older brothers, than with parents who may not have had similar experiences.	Use this when ppnts discuss more meaningful or beneficial conversations about sex with a brother
N - music videos and films are significant in the normalisation of multiple partners as they portray successful Black men with multiple partners and glorify this	
N - no feeling of guilt associated with having multiple partners if honest about your intentions from the beginning and throughout	Use this when ppnts discuss not feeling guilty for having multiple partners because they have been honest with all parties from the beginning
N - no feelings of racism experienced whilst using sexual health services	Use this when ppnts state no encounters of racism experienced from sexual health services
N - no matter what they say, women will catch feelings if you are a respectful and decent guy	
N - not experiencing racism or having to explain racism is key factor in Black men wanting to	Use this when ppnts discuss impact of racism as a reason for choosing to settle down with Black women.

Name	Description
settle down with Black women	
N - openness regarding having a main or other partners is important, particularly when using social media	Use this when ppnts discuss being open about having a main or other partners with new women that they are meeting.
N - parents generally disapproving of multiple partnerships	Use this when ppnts discuss a perception of disapproval from parents towards concurrent partnerships
N - parents need to be realistic about the world young people are living in thus shielding them from sexual content including conversations will not prevent them being exposed to these	
N - partners enjoying sex makes feeds into the Black man's ego as it demonstrates the ability to be a good sexual performer as society expects Black men to be	Use this when ppnts discuss the pride associated with their sexual partners enjoying their sexual encounters and rating it as pleasurable.
N - people are already aware of reasons they should use a condom and the consequenes associated with UPSI thus if they don't then it's their own fault is the consequences occur	Use this when ppnts discuss the inexcusability of not being aware of protective and risky sexual health behaviours
N - perceived beauty of the women you have had sex with matters more than the sheer number of women to friends	Use this when ppnts discuss how ratings received from male peers is influenced by how good looking they perceive the women they are having sex with rather than just how many women
N - perceived discomfort or harm associated with STI symptoms motivates condom use for STI prevention	Use this when ppnts discuss using condoms because they perceive acquiring an STI with a level of discomfort, pain or harm.
N - perceptions of what a man is and does can also come from the negative experiences of your mother who failed to	

Name	Description
receive the support of a man in your father.	
N - performing oral sex is perceived as unhygeinic as the mouth is required to make contact with areas of the body used to eliminate waste from the body	Use this when ppnts discuss perceiving performing oral sex negatively due to contact with parts of the body used to eliminate waste (urine and faeces) from the body
N - performing oral sex on women is publicly perceived negatively among Black men in London, particularly young Black men. The taboo does not always prevent men doing it, but stops them publicly stating they do.	Use this when ppnts discuss the taboo or unacceptability associated with performing oral sex on women
N - personal experiences shape your perceptions of how a real man is supposed to carry himself and behave	
N - pressure to have sex when young sometimes comes from girls as opposed to solely peer pressure from male peers	
N - prevention of pregnancy is valued over STI prevention thus condoms are abandoned when hormonal contraception is in use	Use this when ppnts discuss how they prioritise pregnancy prevention thus are happy to stop using condoms if their partner is using a hormonal contraceptive
N - primary motivation for condom use can alter between STI to pregnancy prevention and vice versa depending on perceptions of sexual partners and relationship value	Use this when ppnts discuss the primary reason for condom use switching depending on how they perceive and value the woman they are having sex with
N - racist sexual stereotypes can make Black men feel very low about themselves	Use this when ppnts discuss the impact of racist sexual stereotypes
N - racist sexual stereotypes pressure Black men to engage	Use this when ppnts discuss the pressure to conform to sexual stereotypes

Name	Description
in sexual behaviours that they do not necessarily want to	
N - several negative emotions are experienced after unplanned condomless sex	Use this when ppnts discuss the negative emotions experienced after unplanned SI as opposed to planned SI.
N - sexual health services are designed to be universal, and to meet everybody's needs as opposed to tailored to one group of people	Use this when ppnts discuss the universal nature of sexual health services.
N - sexual health services are often accessed when symptomatic of an STI	Use this when ppnts discuss accessing a sexual health service as a result of symptoms
N - sexual health services can sometimes perpetuate racial stereotypes about Black mens sexual behaviours and lifestyle	Use this when ppnts discuss racial stereotypes that are perpetuated by sexual health staff
N - sexual health services have focused their attentions on preventing STI and pregnancy, failing to acknowledge the psychological and emotional elements of sex	Use this when ppnts discuss the failure of sexual health services to acknowledge and discuss the psychological, emotional and spiritual elements associated with sex to focus on prevention of biological consequences
N - sexual health services need to adopt and outreach model to target Black spaces	Use this when ppnts discuss the need for sexual health services to engage with Black spaces for outreach to increase awareness and access to services
N - sexual health services need to be discreet in their design	Use this when ppnts discuss the need to be able to access sexual health services discreetly
N - sexual health services need to be more accessible to Black men	Use this when ppnts discuss the need for sexual health services to be more accessible to Black men via various actions
N - sexual health services need to do more to promote themselves to Black men and target them	Use this when ppnts discuss the need to target Black men with promotional information
N - sexual health services should utilise unique	Use this when ppnts discuss the need for sexual health services to use platforms unique to Black men to increase awareness and provide education rather than mainstream platforms

Name	Description
platforms to reach and increse awareness among Black men	
N - sexual relationships with Black women have a more serious feeling to it than those with non-Black women	Use this when ppnts discuss the more serious feeling associated with a relationship with Black women when compared with non-Black women
N - sexualisation of Black male bodies can result in the racism experienced by Black men	Use this when ppnts discuss how the sexualisation of Black male bodies breeds racism as a result of resent or fear among White men
N - some people find porn useful as it introduces them to the differences in women's bodies whilst others find it unhelpful as it creates unrealistic expectations of women's bodies	
N - SRE was pointless as it was heavily focused on the anatomy and physiology of sex	Use this when ppnts discuss not valuing the SRE they received in school because of a major focus on biology
N - the added factors of race and being a migrant means that the term working class only acknowledges White people, who weren't subjected to poverty because of racism and migration	Use this when ppnts discuss identifying as migrant class because working class does not acknowledge the impact of racism and xenophobia on the experience of poverty
N - the hood was an attractive place to girls, who would intentionally come and visit the mandem on the estate.	Use this when ppnts discuss the attractiveness of the hood to girls who weren't from the hood
N - the idea that Black people had to look out for each other influenced the perception of more serious relationships with Black women vs non-Black women	
N - the size of London makes it easier to have multiple partners. This is not the case in smaller towns where	

Name	Description
people are more likely to know each other	
N - the streets provide initial exposure and education about sex and relationships norms and behaviours.	Use this when ppnts discuss initial exposure to sex and relationships via the streets
N - the treatable nature of most STIs makes pregnancy prevention the primary motivation for condom use	Use this when ppnts discuss using condoms to mainly prevent pregnancy because most STIs are treatable
N - there is a norm among Black men in London that promotes and accepts going out, meeting women with the intention of having sex with them in the future	
N - there is a sense of pride associated with having multiple partners as it shows other people, including women that you are experienced	Use this when ppnts discuss pride from having multiple partners because other people perceive them as experienced. This includes women as a perception of experience is associated with good sexual performance
N - there is no need to establish Black only sexual health clinics as experiences with sexual health clinics are not perceived as negatively impacted by race.	Use this when ppnts discuss no need for Black specific clinics or services
N - there is no particular meaning attached to condomless sex when young. Condomless sex can often occur in the heat of the moment or because of a lack of appreciation of the consequences of condomless sex	Use this when ppnts discuss a lack of meaning behind condomless sex when young
N - This generation of Black men are more accepting of having multiple kids with multiple women	Use this when ppnts discuss a normalisation of multiple baby mother's among Black men

Name	Description
N - to ensure comfortability in accessing services, sexual health services need to be staffed with relatable professionals.	Use this when ppnts discuss the need to have staff the can relate to working in sexual health services
N - unintended condomless sex is often accompanied by subsequent feelings of anxiety and worry	Use this when ppnts discuss feeling worried, scared or anxious after UPSI
N - using condoms is sacrificing pleasure and freeness to enable protection	Use this when ppnts discuss having to sacrifice positives of UPSI to enable protection
N - watching porn can be helpful before sexual debut as it teaches how to actually have sex	Use this when ppnts discuss learning how t have sex from watching porn
N - watching porn is often the first time seeing a woman's naked body thus providing education on how a woman's body looks	Use this when ppnts discuss learning about women's bodies from porn.
N - when condoms are not used thoughts are focused on enjoying the experience taking place rather than thinking about STI and pregnancy prevention	Use this when ppnts discuss just being in the moment and not thinking about STIs ad pregnancy when engaging in condomless sex
N - when discussions with parents and family about sex and relationships did happen, they focused mainly on promoting condom use to prevent pregnancy and infections	Use this when ppnts discuss the preventative nature of conversations about sex and relationships with parents
N - when you and all your peers are engaging in the same behaviours it becomes hard to notice what you are actually doing because you are all living it	

Name	Description
N - when young, being SEEN to have multiple girls was probably more important than actually having sex with more than girl because people make assumptions anyways when they visibly see you with multiple girls	Use this when ppnts discuss the importance of being seen with multiple girls because of the assumptions made by other regardless of whether sex was occuring or not
N - when young, friends are usually the primary source of education for sex and relationships content	Use this when ppnts discuss going to friends for information regarding sex and relationships.
N - when young, pressure from peers mocking you for not being sexually active made you feel abnormal and a need to get involved to demonstrate that you are normal	Use this when ppnts discuss wanting to get involved in sexual activity to show they are normal
N - when young, there is a perception that SH services are used when there is something wrong or when you have something. This perception shifts to positive when older	Use this when ppnts discuss the feeling of SH services being used when something was wrong whilst young but now use them as a wellbeing service.
N - whilst having multiple partners is fine, having sex with two on the same day is not fine	
N - whilst porn projects women's bodies in a certain way, it does not always result in unrealistic expectations of womens bodies due to the understanding that porn is unrealistic and every woman's body is different in the real world	
N - whislt young, watching porn results in comparisons of sexual anatomy and performance with porn actors	Use this when ppnts discuss comparing their anatomy and sexual performance with what they have seen in porn clips

Name	Description
N - witnessing your dad fail to live up to expectations of what a man is supposed to do or how a man is supposed to treat his family shows you what type of man you do not aspire to be	
N - women embrace the challenge to try and be the one to get you to lock off all your other partners and become exclusive to them	
N - women friends tend to disapprove of multiple partners	Use this when ppnts discuss perceiving disapproval from women friends about having multiple partners
N - young Black boys SRE need to start from young, particularly schools	Use this when ppnts discuss the need to start educating young Black boys from young
N - young Black men are exposed to false narratives RE sex and r'ships through music and porn. These need to be countered with factual education	
N - young Black men cannot be seen to be going above and beyond for girls because it is not perceived as manly	
N - young Black men feel powerful when they receive stigmatised sexual acts from girls but do not perform these same acts.	Powerful does not relate to physical power. Powerful relates to a sense of respect and authority received from other people, both boys and girls. This feeling of powerful comes from knowing that there is a social consequence attached to the girls performing these acts on them but they do so regardless.
N - young Black men receive ratings for having multiple partners	Use this when ppnts discuss positive recognition associated with having multiple partners as a young man

7.9 Appendix I: 15-Point Checklist of Criteria for Good Thematic Analysis Process (Braun & Clarke, 2006)

Transcription	1.	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2.	Each data item has been given equal attention in the coding process.
	3.	Themes have not been generated from a few vivid examples (an anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive.
	4.	All relevant extracts for all each theme have been collated.
	5.	Themes have been checked against each other and back to the original data set.
	6.	Themes are internally coherent, consistent, and distinctive.
Analysis	7.	Data have been analysed – interpreted, made sense of- rather than just paraphrased or described.
	8.	Analysis and data match each other – the extracts illustrate the analytic claims.
	9.	Analysis tells a convincing and well-organised story about the data and topic.
	10.	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11.	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12.	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13.	There is a good fit between what you claim you do, and what you show you have done – ie, described method and reported analysis are consistent.
	14.	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15.	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

(Braun & Clark, 2006, p37)

Ethical Review Application Form

Please complete **Relevant** sections of the form.
If you think a question is not applicable to your project, please provide an explanation as to why you think so.

Section 1: Applicant Details	
First Name	Uzochi
Last Name	Nwaosu
Faculty	HAS
Department	Psychology
Co-researcher Names (internal and external) Please include names, institutions and roles. If there are no co-researchers, please state N/A.	N/A
Is this application for a staff or a student?	Student
Student Course details	Postgraduate Research
Name of Director of Studies / Supervisor	Dr. Jane Meyrick
Comments from Director of Studies / Supervisor *For student applications, supervisors should ensure that all of the following are satisfied before the study begins:* • *The topic merits further research;* • *The student has the skills to carry out the research;* • *The participant information sheet is appropriate; and procedures for recruitment of research participants and obtained informed consent are appropriate.* *The supervisor must add comments here. Failure to do so will result in the application being returned*	
This piece of work follows on from a mapping of the gap in the evidence base around condom use and Black men internationally and this work will begin to address this in a geographically located population in London. Uzochi is a trained sexual health advisor already working with this population in a clinical role and is therefore well placed to carry out a research role.	

Section 2: Project	
Section 2:1 Project details	
Full Project Title	
An exploration of the sexual health experiences and motivators of Black British men in East London: A qualitative study.	
Project Dates These are the dates for the overall project, which may be different to the dates of the field work and/or empirical work involving human participants.	
Project Start Date	09/11/2020
Project End Date	01/04/2022
Dates for work requiring ethical approval	

You must allow **at least 6 weeks** for an initial decision, plus additional time for any changes to be made.	
Start date for work requiring ethical approval	06/11/2020
End date for work requiring ethical approval	31/05/2021
How is the project funded? (e.g. externally, internally, self-funded, not funded – including scholarly activity) Please provide details.	
Self-funded	
Is external ethics approval needed for this research?	No
If Yes please provide the following: For NHS Research please provide a copy of the letter from the HRA granting full approval for your project together with a copy of your IRAS form and supporting documentation, including reference numbers. Where review has taken place elsewhere (e.g. via another university or institution), please provide a copy of your ethics application, supporting documentation and evidence of approval by the appropriate ethics committee.	
Click or tap here to enter text.	

Section 2:2 Project summary

Please provide a concise summary of the project, including its aims, objectives and background. (maximum 400 words)
Please describe in non-technical language what your research is about. Your summary should provide the committee with sufficient detail to understand the nature of the project, its rationale and ethical context.

Rates of Sexually Transmitted Infections (STIs) continue to present the United Kingdom (UK) with significant challenges (Public Health England, 2019). Worrying disparities, including poor sexual health outcomes among certain groups, remain a prominent issue and masked by progress in general population sexual health outcomes (Health and Social Care Committee, 2019). Since the late 1980s, people of Black ethnicity have experienced a disproportionately high burden of STIs in the UK (Wayal et al., 2017a, 2018).
The disproportionately high burden of STIs observed among people of Black ethnicity in general can be explained by the greater likelihood of reporting concurrent partnerships (Wayal 2017a) observed within this population. Concurrent relationships have been found to be more common among men of Black ethnicity when compared to their White counterparts (Wayal et al., 2017b).
The high burden of STI rates among people of Black ethnicity can also be explained by the higher rates of condomless sex (Elam, Fenton, Johnson, Nazroo, & Ritchie, 1999; Wayal et al., 2017a) within this population. One study revealed condomless sex with more than one partner in the past year was more commonly reported by BC men (11.6%) and BA men (7.7%) than their White British counterparts (7.4%) (Wayal et al., 2017).
Cultural and social factors are said to influence behaviours that increases susceptibility to poor sexual health outcomes among Black men. Individual sexual health outcomes can be largely influenced by their social environment as a result of factors including peer influence and sexual networks (Baker et al., 2012). It has been argued that among second and third generation ethnic minorities, the shared education and societal experiences and influences associated with being London born and educated may result in peer, urban youth culture superseding ethnic based cultural influences on sexual health beliefs and behaviours (Connell, McKevitt & Low, 2001).

This study aims to explore the psychological processes associated with sexual behaviours including, multiple sexual partners and condomless sex, and explore the role of local peer culture on sexual attitudes, motivators and behaviours. It is anticipated that the findings of this study will contribute to the underpinning of behavioural interventions to improve sexual health outcomes among Black men as the findings can provide the understanding required to develop local profiles of social and psychological influences on sexual behaviours which are significant to developing targeted interventions. The findings can also support to develop culturally sensitive clinical and community sexual health services for Black men in the UK.

What are the research questions the project aims to answer? (maximum 200 words)

What does it mean to be a Black British man from East London (Hackney/Newham)?

How does the experience and understanding of being a Black British man from East London (Hackney/Newham) inform sexual attitudes, relationships and behaviours?

What is the East London (Hackney/Newham) Black British male experience of sexual partnerships, including concurrent partnerships and motivators of condom use within these?

What do Black British men from East London (Hackney/Newham) describe as their motivators for condom use and how does this inform their STI and pregnancy prevention efforts?

What is the experience of racism among Black British men from East London (Hackney/Newham) and how does this experience inform engagement with sexual health services and interventions?

Please describe the research methodology for the project. (maximum 250 words)

Design

A qualitative, phenomenological approach with in-depth, semi-structured interviews will be used as it has been identified as the most appropriate method for an in-depth exploration of personal meanings of individual's lived experiences and behaviours (Polgar & Thomas, 2000; Rossman & Rallis, 2003).

Sample

Long interviews with 10 participants has been recommended for a phenomenological study (Cresswell, 1998). To obtain a variety of accounts and adhere to study logistics and timeframe, the sample will be consist of 10 heterosexual, Black men from two East London borough's, Hackney and Newham. Participants will be recruited from barbershops as within the Black community, barbershops have been identified as racially and culturally specific physical spaces in the neighbourhood that hold intrinsic value, provide ethnic-specific social resources and create a sense of belonging (Reynolds, 2013). Barbershops therefore provide access to Black men who may not be accessed at mainstream health services like sexual health clinics.

Materials

Semi-structured interview questions will be used to provide guidance and help direct responses. Qualtrics online survey tool will be used to create an informational page detailing the research aims, research questions, benefits and obtain consent. Interviews will be audio-recorded, securely stored and managed. Participation will be compensated with a free shape-up or haircut up to the value of £20. This will be self-funded.

Procedure
A PPI advisory group will be recruited to comment on various aspects of the research including the design of research materials (study poster and interview questions) and dissemination of findings. The group will also contain a barber who will be consulted on the practicalities of proposed recruitment from barber shops and compensation in the form of free haircut or shape-up.
Should barbershops reopen following the covid-19 pandemic, the study poster will be displayed in barbershops across Hackney and Newham. Barbers will be asked to alert customers of the study and encourage participation. If barbershops remain closed due to covid-19, Hackney and Newham based barbers will be asked to share the study poster and registration link to their many followers on Instagram. Having used Qualtrics survey to register an interest, participants volunteering and meeting the study eligibility criteria will be contacted by phone to confirm their consent, and arrange an interview date/time. Interviews will be held via Skype, Facetime or WhatsApp. During interviews, participants will be reminded of the voluntary and confidential nature of their participation and their right to withdraw from the study. Participants will be informed of my duty to breach confidentiality should they disclose information that suggests that they, or somebody else may be at risk of harm. Upon conclusion of the interview, participants will be debriefed, including information about how to withdraw from the study, how to redeem their free shape-up/haircut voucher and signposted to local sexual health and relevant support services.

Section 3: Human Participants	
Does the project involve human participants or their data? *If not, please proceed to Section 5: Data Collection, Storage and Disposal, you do not need to complete sections 3-4.*	Yes
Section 3.1: Participant Selection	
Who are your participants?	
Heterosexual Black men residing in London Boroughs of Hackney and Newham.	
Will you be recruiting students as research participants who are from outside your faculty and/or from multiple faculties? If you plan to recruit student participants from across UWE (rather than solely from your home faculty) your ethics application will be reviewed by UREC instead of the FREC.	No
Please explain the steps you will take to select your participant sample.	
Ideally, participants would be recruited from barbershops in London boroughs of Hackney and Newham. Should barbershops remain closed due to covid-19, Hackney and Newham based barbers will be asked to share the study poster and registration link to their many Instagram followers. The poster will detail the study aims and research questions, emphasise the voluntary and confidential nature of the research and promote the post-interview free shape-up or haircut incentive. Posters shared on social media will be accompanied by a registration link to take participants directly to the study Qualtrics page where participants can register their interest to participate, complete a consent form and schedule an initial telephone consultation. Posters displayed in barbershops will contain a QR code that can be scanned with a smartphone. Should more than 10 people register an interest to participate, a purposeful sampling technique will be employed to select the final 10 participants, acknowledging a variety in	

demographic factors including age, ethnicity and place of birth of participants and ensuring the wide range of accounts are collected.

Please explain how you will determine the sample size.

Long interviews with 10 participants has been recommended for a phenomenological study (Cresswell, 1998), therefore a sample size of 10 participants will be selected, in line with the study logistics, time constraints and resources. A sample of 10 participants also enables an acquisition of a variety of accounts and variation in participant demographic factors including ethnicity and age.

Please tell us if any of the participants in your sample are vulnerable, or are potentially vulnerable and explain why they need to be included in your sample.

NB: Please do not feel that including vulnerable, or potentially vulnerable participants will be a bar to gaining ethical approval. Although there may be some circumstances where it is inappropriate to include certain participants, there are many projects which need to include vulnerable or potentially vulnerable participants in order to gain valuable research information. This particularly applies to projects where the aim of the research is to improve quality of life for people in these groups.

Vulnerable or potentially vulnerable participants that you **must** tell us about:

- Children under 18
- Adults who are unable to give informed consent
- Anyone who is seriously ill or has a terminal illness
- Anyone in an emergency or critical situation
- Anyone with a serious mental health issue that might impair their ability to consent, or cause the research to distress them
- Young offenders and prisoners
- Anyone with a relationship with the researcher(s)
- The elderly

No vulnerable participants will be recruited.

Section 3.2: Participant Recruitment and Inclusion

How will you contact potential participants? Please select all that apply.

☒ Advertisement
☐ Emails
☐ Face-to-face approach
☐ Post
☒ Social media
☒ Telephone calls
☒ Other
If Other, please specify: Video calls via Skype, Facetime or WhatsApp video.

What recruitment information will you give potential participants?
Please ensure that you include a copy of the initial information for participants with your application.
Research Template Participant Information Sheet
Research Template Privacy Notice

Participation information sheet
Privacy notice

How will you gain informed written consent from the participants?
Please ensure that you include a copy of the participant information sheet and consent form with your application.
Research Template Consent form
Research Template Privacy Notice

Consent form to be completed electronically on the Qualtrics platform. Consent will be confirmed at each subsequent contact between researcher and participants. As this study is being conducted to underpin development of future interventions, participants can consent to register an interest to be involved in a PPI group for development of future interventions.
What arrangements are in place for participants to withdraw from the study?
Participants will be reminded of the voluntary nature of the research at each contact. Participants will be debriefed at the end of interviews, reminding them of their right to withdraw. Participants will be provided with contact details for the researcher and Director of Studies, and a participant number which will enable them to be identified should they choose to withdraw from the study until the point of anonymisation of data. This will only be possible until analysis has been completed.

Section 4: Human Tissue	
Does the project involve human tissue?	No
If you answer 'No' to the above question, please go to Section 5 Please describe the research methodology that you will use. This should include an explanation of why human tissue is required for the project and a description of the information that you and the research team will have access to about the participants/donors.	
Click or tap here to enter text.	
Please describe how you propose to obtain/collect, process, securely store and dispose of the human tissue.	
Click or tap here to enter text.	
Please explain if and how samples will be anonymised. Where samples are not anonymised, please explain how confidentiality will be maintained, including how this information will be securely and appropriately stored and disposed of.	
Click or tap here to enter text.	

Section 5: Data Collection, Storage and Disposal
Research undertaken at UWE by staff and students must be GDPR compliant. For further guidance see Research and GDPR compliance ☒Please confirm that you have included the UWE Privacy Notice with the Participant Information Sheet and Consent Form ☒ By ticking this box, I confirm that I have read the Data Protection Research Standard, understand my responsibilities as a researcher and that my project has been designed in accordance with the Standard.

Section 5.1 Data Collection and Analysis
Which of these data collection methods will you be using? Please select all that apply.
☒ Interviews ☐ Questionnaires/surveys

☐ Focus groups
☐ Observation
☐ Secondary sources
☐ Clinical measurement
☐ Digital media
☐ Sample collection
☐ Other
If Other, please specify: Click or tap here to enter text.
Please note that online surveys must only be administered via Qualtrics
Please ensure that you include a copy of the questionnaire/survey with your application.

What type of data will you be collecting?

☐ Quantitative data
☒ Qualitative data

Please describe the data analysis and data anonymisation methods.

Participants will be allocated a participant number to allow identification in the case of a withdrawal request up to the point of transcription. Interviews will be transcribed to create anonymised interview/data transcripts in word format and stored on UWE one drive. This data will have had all identifiable features removed.
Thematic analysis will be used to explore and identify patterns, and draw interpretations from the data. Thematic analysis, described as "a method for identifying, analysing and reporting patterns within data" (Braun & Clarke, 2006), is widely recognised as an appropriate method for acquiring and providing a comprehensive account of qualitative data.

Section 5.2 Data Storage, Access and Security

Where will you store the data? Please select all that apply.

☐ H:\ drive on UWE network
☐ Restricted folder on S:\ drive
☒ Restricted folder on UWE OneDrive
☐ Other (including secure physical storage)
If Other, please specify: Click or tap here to enter text.

Please explain who will have access to the data.

Researcher, Director of Studies and second supervisor. A transcription service may be used to transcribe interviews. In line with UWE data management guidelines, only a transcription company or contractor that has a formal data processing agreement with UWE will be used. Interview recordings will only be shared with transcription services where the participant has consented. Participants who do not consent to this will not have their interview transcribed by a transcription service.

Please describe how you will maintain the security of the data and, where applicable, how you will transfer data between co-researchers.

Data will transfer between Director of Studies, second supervisor and I via UWE one drive only. I will create a restricted folder on UWE one drive and share access with Director of Studies and second supervisor.

Section 5.3 Data Disposal

Please explain when and how you will destroy personal data.

Except participants who have consented to participating in a later PPI group, personal data will be securely destroyed at the point of transcription of interviews, 5 months after date on signed consent form. Data will be destroyed via secure deletion.

Section 6: Other Ethical Issues

What risks, if any, do the participants (or donors, if your project involves human tissue) face in taking part in the project and how will you address these risks?

The sensitive nature of the topic being researched may evoke negative emotions such as anxiety or distress, associated with recalling and discussing negative sexual experiences, experiences of racism and negative childhood and adolescence experiences. Type and content of questions will be shared before the interview and informed consent acquired. To promote emotional wellbeing of participants, where needed, participants will be signposted to local counselling and sexual health services for specialist support. The interview will be stopped at any sign of participant distress. Participants will be informed of their right to stop the interview at any point should they feel uncomfortable. Participants will be encouraged to take regular breaks if needed. Participants will be able to contact me or my Director of Studies via email, even after the interview has concluded. Participants will be supplied with information for various support services during debrief.

Are there any potential risks to researchers and any other people as a consequence of undertaking this project that are greater than those encountered in normal day-to-day life?
For further information, see guidance on safety of social researchers.

No risk to researcher. No face-to-face interviews will be conducted.

How will the results of the project be reported and disseminated? Please select all that apply.

☒ Peer reviewed journal
☒ Conference presentation
☐ Internal report
☒ Dissertation/thesis
☒ Written feedback to participants
☐ Presentation to participants
☐ Report to funders
☐ Digital media
☒ Other
If Other, please specify: Instagram

Does the project involve research that may be considered to be security sensitive? For further information, see UREC guidance for security sensitive research.	No

Please provide details of the research that may be considered to be security sensitive.

Click or tap here to enter text.

Does the project involve conducting research overseas?	No
Have you received approval from your Head of Department/Associate Dean (RKE) and is there sufficient insurance in place for your research overseas?	Not applicable

Please provide details of any ethical issues which may arise from conducting research overseas and how you will address these.

N/A

Section 7: Supporting Documentation

Please ensure that you provide copies of all relevant documentation, otherwise the review of your application will be delayed. Relevant documentation should include a copy of:

- The research proposal or project design.
- The participant information sheet and consent form, including a UWE privacy notice.
- The questionnaire/survey.
- External ethics approval and any supporting documentation.

Please clearly label each document - ensure you include the applicant's name, document type and version/date (e.g. Joe Bloggs - Questionnaire v1.5 191018).

Section 8: Declaration

☒ By ticking this box, I confirm that the information contained in this application, including any accompanying information is, to the best of my knowledge, complete and correct. I have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my obligations and the right of the participants.

Name: Uzochi Nwaosu
Date: 14/05/2020

This form should be submitted electronically to the Research Ethics Admin Team: researchethics@uwe.ac.uk and email copied to the Supervisor/Director of Studies where applicable, together with all supporting documentation (research proposal, participant information sheet, consent form etc).

Please provide all the information requested and justify where appropriate.

For further guidance, please see http://www1.uwe.ac.uk/research/researchethics (applicants' information)

7.11 Appendix K: Ethics approval letter

Removed as it contains personal identifiable information.

7.12 Appendix L: Excerpts from research diary

06/09/20: Initial interview

Prior to this interview, I was experiencing various emotions. Excitement to get started but also nervous as I did not know how the interview would go. However, soon into the interview I felt at ease and ultimately enjoyed the interview. I felt this was an open, honest conversation and felt this participant just kept it real all the way in discussing his experiences.

I noticed I found myself avoiding seeking clarification and elaboration at times when discussing topics pertaining to fatherhood. Whilst probing may have resulted in a more in-depth understanding about his mindset, I was mindful that before we started the official interview, we spoke about his strained relationship with his baby mother and how this had impacted his ability to be what he considered to be a good father. I therefore did not want to push for more discussion on this topic and risk causing distress. I think for future interviews I will advise participants that they are more than welcome to say that they do not wish to answer when feeling uncomfortable. After all, I was fortunate to have an open conversation with this participant before the interview started but this will not always be the case and I will be unaware of sensitive or sore topics for participants.

04/11/20: Second interview

This interview started well, but at times I felt really uncomfortable at hearing the misogynistic terms that were being used to describe women in relation to their sexual behaviours. I felt these terms would never be directed towards men exhibiting the same behaviours. I think having to remain impartial was a struggle. In real life, if a friend or acquaintance was using these terms to describe women, I would confront them about the use of these terms and possibly engage them in dialogue about why the terms being used are inappropriate and misogynistic. However, I couldn't do that in this situation and just had to sit with the discomfort and allow the interview to proceed naturally. Furthermore, I had to hide my discontent at the terms being used and either awkwardly laugh or just ignore. Nevertheless, the interview produced a good level of insight despite my discomfort.

15/11/20: Third interview

This interview was tough at times, especially when discussing race related topics. One particular moment stands out to me, When I asked him what does it mean to be a Black man and he said “that is only to be born in the skin, to be born Black”.

I felt this was such a simplistic way to view something so significant in the lives of many and probably his whether he realises it or not. On reflection, he’s not to blame though. Not to sound patronising, but he is still young and yet to develop a deeper understanding of the complex and nuanced ways that racism is perpetrated. Honestly, it took me back to when I was his age myself and reminded me of how naïve we can view our social and environmental surroundings at that age. The simple way we view the world and our interactions with people in it. It is almost protective in a way as the less you know the less it hurts when racially motivated incidents occur. I really hope, for his sake, that he is right, and that his future experiences are not influenced by his race and gender, and that being a Black man can remain just meaning that he was born as a male in Black skin. Unfortunately racism exists in the world and he will most likely experience it, even in the most subtle ways. And as he gets older, he will most likely develop an awareness of the way that his race, gender and a combination of the two have influences the way is treated across various contexts.

05/01/21: Transcribing interviews

Before delving into the mighty task of transcribing the data, I felt I needed to listen to the recorded interviews at least once. This helped me become more familiar with the data. It also helped me to contextualise the data in consideration of verbal communication cues that would be lost once transcribed. For example, many times, a laugh wasn’t just a laugh. The nature of laughing varied at times but this will not be reflected on transcripts, where laughs will be represented by the word “laughs” in italicized font.

The process of transcribing these interviews showed me how much the participants appreciated speaking to me, a fellow Black man about their experiences. The warmth and rapport that was present in the dialogue was evident and filled me with joy. Many cultural idioms were used, demonstrating a relaxed approach, cultural familiarity and that they were not being judged. I feel, the richness of data obtained as a result of this cannot be underestimated. Ultimately, I feel Black men are not hard to reach or engage with research. They just need to be provided with a trusting space that enables them to feel safe to discuss

personal and sensitive experiences without fear of exploitation or harm. They need to see the relevance of the research being conducted and need to sense that researchers are being genuine.

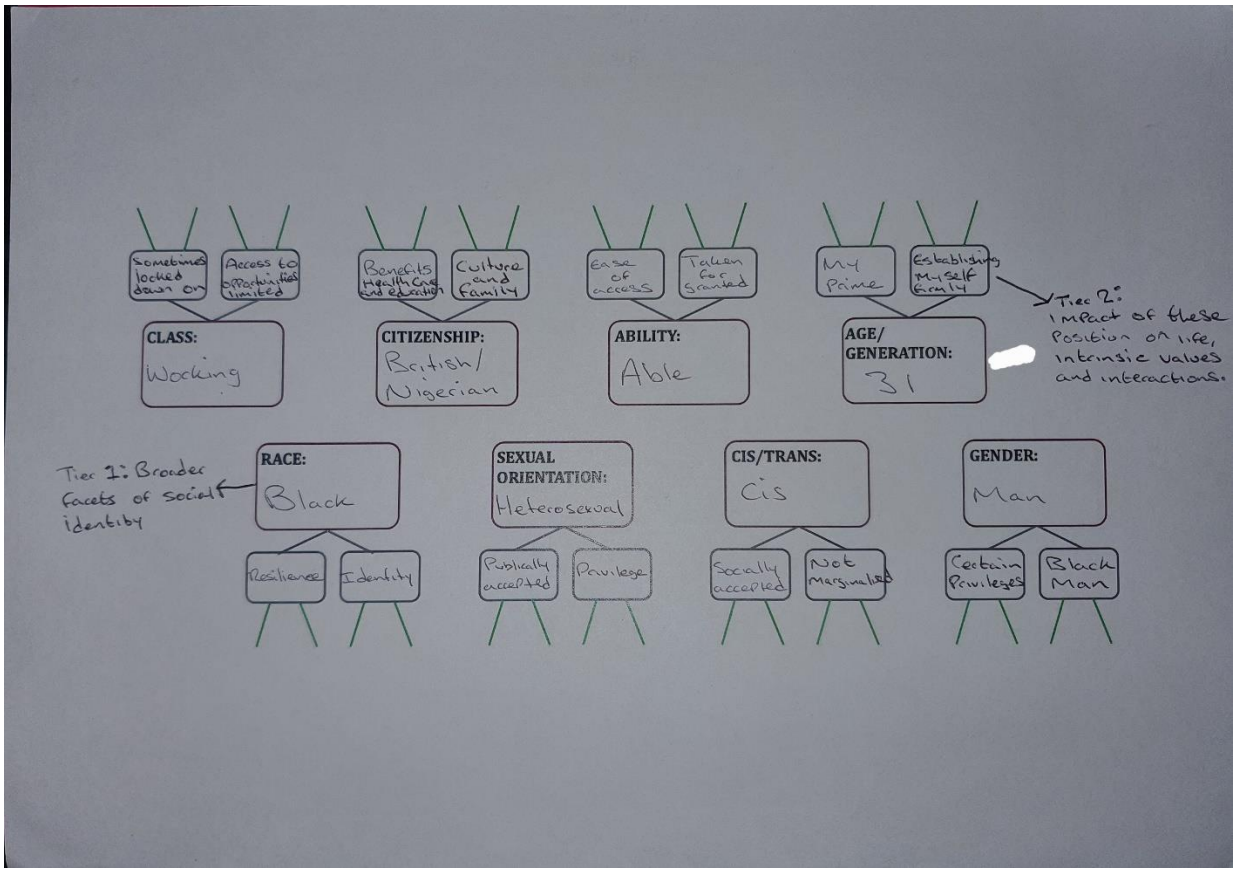
12/03/21: Analysing the data

I found it hard to separate myself from the data but I struggled. After all, some of what I had heard from participants was my reality too. I too am a Black heterosexual man from London and therefore identified similarities in our experiences. I couldn't approach analysis from a completely impartial perspective and being transparent about this contributes to the credibility of the research. Whilst not totally detached, I remained conscious of my biases towards the data I was analysing. Surprisingly, hearing contrasting experiences was useful to me as it helped keep me grounded and open minded in my analysis. It meant I had to engage in critical thinking as it wasn't as simple as "A means B because it's what happened to me". It meant that different meanings were constructed because of the variation in experiences.

My analysis did however highlight how misunderstood Black men are by society. Alongside this, who bothers to ask? Who bothers to appropriately and sensitively investigate? Rather, Black men are subjected to people's interpretations of their behaviors underpinned by outdated, questionable literature often underpinned by racist narratives. These interpretations then result in the mistreatment that we see by institutions across the education system, health services and criminal justice system. This filled me with a sense of frustration, but also a sense of determination. Determination and motivation to tell their stories. To highlight that whilst my data has highlighted some unique ways that can influence the sexual attitudes, behaviours and relationships of Black men, there are also similarities to other groups with greater sexual health needs yet these groups are not subjected to controversial explanations.

Even reflecting on my entries in this diary has me questioning why I am speaking about Black men in the third person as if I am not a Black man. It feels uncomfortable because I am proud to be a Black man and speaking about Black men using terms like "they/their" makes it seem as if I am trying to separate myself from them. This serves as an example of some of the unexpected challenges encountered during this process.

7.13 Appendix M: Social positionality map



7.14 Appendix N: Reflective chapter

Background/developing the study

Soon after starting the Professional Doctorate in Health Psychology, I was required to decide on a research topic which guided the systematic review I conducted (appendix A). Having worked with young people for the entirety of my career, naturally I was interested in pursuing research on the sexual health needs of young people. However, I was also drawn to research on another subgroup with greater sexual health needs, Black men. Ultimately, I felt I needed to take my career in a different direction and start exploring sexual health amongst other groups in the population aside from young people.

Conducting the systematic review was an eye-opening experience for me which highlighted the significant racial and ethnic disparities observed amongst Black ethnic groups in the United Kingdom (UK). Furthermore, I also noticed a lack of interventions aimed at addressing these disparities which cannot be said for other identified subgroups with greater sexual health needs. I asked myself why. I very quickly recalled memories of visiting my General Practitioner (GP) as a 21 year-old and noticing a caution on the computer screen advising the GP to offer me a Chlamydia test solely because of my age. I am also aware of the efforts exerted to provide health promotion interventions to men who have sex with men (MSM) within sexual health services. However, I struggled to identify interventions aimed at people of Black ethnicity. Was this by coincidence or was this an example of structural racism preventing the sexual health needs of Black people from being prioritised as much as other subgroups with greater sexual health needs. Nevertheless, an interest in the sexual health needs of Black men was ignited.

In considering ideas for this study, I noticed a limited amount of literature on Black masculinity and Black male sexuality in a UK context. Naturally, I felt an unrealistic urge to want to fill all these gaps in literature and design a study with the potential to produce the answers to all questions regarding Black male sexuality. I knew this was unrealistic and was very quickly reminded by my Director of Studies (DoS) that this process marks the beginning of my research career and can underpin future studies. Furthermore, my systematic review findings pointed me in a specific direction as a starting point towards developing interventions aiming to improve sexual health outcomes amongst Black heterosexual men in the UK. A qualitative study to understand experiences which would also enable me to

explore elements of Black masculinity and Black male sexuality in a UK context. I felt the qualitative nature of the study would allow me to tell my participants' stories with their voices at the centre of my research.

Design

Having never conducted qualitative research in the past, I felt various emotions at the prospect of doing so. Fearful, doubtful and excitement were the main emotions experienced. I was excited at the amount of data I would obtain and the richness of this data. I was also excited about using the data to tell a story. However, I didn't realise just how philosophical and theoretical qualitative research was. The various epistemologies and ontological positions. This was all very new to me and required a lot of reflecting to identify my views and align them with a paradigm. This filled me with fear and left me doubting whether I could conduct a qualitative piece of research at doctoral level. All of a sudden, I had realised that conducting qualitative research required more than just interviewing participants, transcribing data and writing up my findings. Reflexivity, trustworthiness, rigour and transferability were new concepts to me which I needed to familiarise myself with to ensure the study was conducted appropriately.

Developing the interview guide

Initially, I struggled to devise an appropriate interview guide (appendix B). Ultimately, I wanted to ensure I was gathering a rich amount of data that would answer my research questions. However, I wanted to make sure that my questions were relevant and did not want participants feeling I was being too nosey with my questioning.

There was very little guidance to lean on as this topic had barely been researched in the UK. Fortunately, my literature review alerted me to a previous study (Gerressu, 2016) which has explored a similar concept but amongst young Black Caribbean men. Reading this study reassured me that I was on the right track and my line of questioning was justified.

Whilst I was aware that the interview guide was just a guide and that follow-up questions during actual interviews would depend on responses received, I still felt that I needed to reflect on the purpose of each question to ensure these were appropriate. The clarity and feedback received from my supervisory team helped me to strike the right balance in the

questions being asked and ensured that questions were neither too vague nor inappropriately direct.

Recruitment

I was aware of the difficulties researchers can sometimes experience when sometimes recruiting Black people as research participants (Shavers, 2001). As a Black man, I am also personally aware of the lack of trust Black people have in researchers, and particularly those from academic and medical institutions (Scharff et al., 2010). Personally, I do not blame them. I feel the lack of trust is justified considering the way Black people have been treated by society and the way researchers have exploited Black bodies for their own gain (Thomas & Quinn, 1991; Spigner, 2007). To find participants, I needed them to have trust in me and the research I was conducting. I needed them to be confident that I would not be exploiting them for my own purposes. I felt the first step in doing this would be recruiting from an environment that Black people feel comfortable attending.

I was confident in my recruitment strategy and felt I would be able to recruit the required numbers of participants required. Why? As a Black man who frequently attends barbershops, I am always fascinated to see and hear the nature of discussions and debates that occur frequently within that space. Topics range from reality television, sports, mental health, sexual health and relationships. As a matter of fact, my recruitment strategy was thought of whilst waiting in a barbershop for a haircut. Five other Black men were present alongside two barbers. Unexpectedly, a conversation was initiated about syphilis and the Human Immunodeficiency Virus. Unfortunately there was a lot of misinformation about these infections within this discussion. Fortunately, as a sexual health practitioner I was able to clarify misconceptions. This experience made me realise that Black men are not resistant to talking about sexual health and other sensitive issues so long as they feel the forum which facilitates this discussion is safe. This reinforced the idea that the barbershop can be a safe space for Black men to discuss sensitive issues which made it feel like the right place to recruit participants from. I also managed to come across literature which has discussed the sentimental value of barbershops (Barry & Roper, 2016; Roper & Barry, 2016) and why this makes the barbershop a good place to find Black men who may not be engaged with mainstream health services like sexual health clinics.

Interviewing

I initially planned to conduct in-person face-to-face interviews as I felt this would enable a more natural feel to the interview and encourage rapport. However, the coronavirus pandemic forced me to switch to virtual interviews and on reflection, I feel these worked better than an in-person face-to-face interview would have. Whilst I can only imagine what the in-person face-to-face experience would have been like, I just feel that allowing participants to be interviewed from the comfort of their homes (as they usually were) with a device between us made participants feel more comfortable in discussing their experiences.

Slight frustration was experienced occasionally as I tried to schedule interviews at times that were convenient for participants. Often, this meant interviewing in the evening after work and on weekends whilst also trying to cater to two young children. At times interviews were rescheduled at short notice. Despite this, conducting the interviews was the most enjoyable part of the research process for me. There was just something striking about two Black men sitting down and having a conversation. The use of cultural idioms, no judgement, no reprimanding, and no debating. Just two Black men sat and talking about the participant's experiences and how this has been shaped by their Black masculinity. A lot of disclosed experiences resonated with my own experiences. There were similarities in the participants' experiences, but there was also variation. This reinforced the notion that there is no one way to being a Black man.

Being new to this type of research, I feel that I approached the first interview with nerves and naturally sought solace in my interview guide. I could have sought clarity more often and pressed for elaboration more. I feel that my interview style improved as I conducted more interviews. I noticed I became more relaxed in my approach to questioning and let the participants dictate the order of the interview rather my being strict with my interview guide. The relaxed nature of subsequent interviews was reflected in the lengthier duration of these.

Transcribing and data analysis

Before transcribing, I felt I needed to repetitively listen to the interviews to familiarise myself with the content and nature of discussions. I feel this familiarity helped me with transcribing the interviews and ensured the data did not feel foreign. The data felt like my own and made the process feel more authentic. Listening back to the interview audio, I

realised that whilst interviewing, I was consumed by the enjoyment of conducting the interviews and asking the right questions that I did not realise exactly how comfortable and relaxed participants and I felt. I did not know the participants, but a sense of familiarity was exuded when listening back to the interviews. It was almost as if I had known the participants, and this was a conversation between two friends rather than a research interview.

The actual transcribing process felt overwhelming. I was investing approximately 3-4 hours transcribing each hour of audio. This felt like a never-ending task, but I subsequently recognised the benefit associated with transcribing interview data. It provided me with a level of familiarity with my data that now enables me to read quotes from the study and identify the exact participant the quote originated from. Furthermore, I can recall the interview and even remember the tone that the quote was verbalised in.

The process of analysing the data was also lengthy. As someone who is new to qualitative research, I feel I made novice mistakes. Up to this stage, I felt that I was being guided through each phase by standardised and self-explanatory principles that were relevant to each stage of the research. For example, the transcribing process was self-explanatory, and the literature review process was guided by standardised principles. However, when I reached the data analysis stage, the unique nature of my data made the process feel lonely and guideless, as if I was learning to ride a bike and my stabilisers had just been removed.

Unsurprisingly, my initial codes were very surface-level and descriptive. They lacked interpretation, almost as if I was trying too hard to separate myself from the data and process. Thankfully my supervisory team were available to regularly review my outputs and advise me on shortcomings. They reassured me that mistakes I had made were common amongst students who were new to qualitative research and pointed me in the correct direction, like parents gently encouraging a child back onto their bike after falling off.

I routinely reflected during this process and this sparked changes in the way I was proceeding with my analysis. For example, on reflection, I found that some themes overlapped, some did not make sense and that some did not warrant standing as a theme on their own but rather as a sub-theme. Ultimately, the transcribing and data analysis processes were the most challenging aspects of the research for me, but the skills I have

developed from engaging in the processes will shape my career as a researcher in the future.

Engaging in supervision

I am thankful to have been supervised by experienced and knowledgeable researchers. Alongside their experience in research, my supervisory team were experienced supervisors. I feel that they knew exactly what to say to me at exactly the right time. They knew when to empathise and when to constructively criticise. At times when I was experiencing imposter syndrome, the tone of their criticism was pitched perfectly and provided with the shot of energy I needed to get myself going again.

Final reflections

I feel a sense of achievement having completed this study. Not only did I take on the challenge of designing and conducting a qualitative piece of research, the topic that was researched is of great importance and tells the story of a marginalised group who seldom have their voices heard and listened to.

Whilst frustrating at times, on reflection, I feel I have thoroughly enjoyed challenging myself by navigating the qualitative research process. I am still far from an accomplished researcher and would benefit from further training and guidance. As my DoS once said, “the doctoral process is not for experienced researchers but is a training programme that teaches someone how to research”. I have realised that I am not supposed to feel like an accomplished researcher at the end of the process. In fact, it would be somewhat arrogant to feel so. However, I feel the process of conducting this study has increased my confidence as a researcher and as a sexual health practitioner. The process has increased my familiarity with the limited literature on Black masculinity and Black male sexuality. I feel confident discussing the literature and gaps within it. Furthermore, I have contributed to the limited literature and hope this study can underpin future research.

My research feels real. It is the real-life experiences of a marginalised group with their voices. I read through my results section, and I can hear the participants telling their stories all over again. I hope readers enjoy reading this study and acknowledge the experiences of participants. Whilst not representative of the experiences of all Black men, I hope readers

can understand Black men a little bit more and provide them with safe forum to tell their stories.

I would love to conduct more research but would need this to be part of my day-to-day role as opposed to something in addition to my role to enable a healthy work-life balance.

Going forward, I want this study to be acknowledged beyond the realms of academia. I now aim to disseminate my findings in various formats, including formats that are relatable and accessible to wider members of the Black male population.

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