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# Barriers to Condom use Among "Socially Damaged Women": A Qualitative Study in Iran

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**One of the most effective strategies to prevent transmission of sexually transmitted infections (STIs) is use of condom, but obstacles to its use in high-risk groups have not yet been fully understood. The main objective of our study is to evaluate barriers to condom use among "Socially damaged women" (SDW). A qualitative method was utilized. Two focus group discussions (FGDs) and eighteen semi-structured in-depth interviews were conducted with SDW, 15-45 years old, at shelters and harm-reduction drop-in-centers in Tehran, Iran. Data was analyzed using the content analysis approach. All women in the study were sexually active and most of them were divorced. They all had primary school education at a minimum, and a limited knowledge of HIV and STIs, yet the rate of condom use in these high-risk groups are low. The most common obstacles to consistent condom use among "SDW" included misperception, low perceived sensitivity and self-efficacy partner objections. Hence, preventions strategies based on increasing knowledge about STIs and condom use, self-efficacy, perceived sensitivity must be designed and improvised to induce condom use. These data will be useful in designing and improving STIs prevention outreach programs in Iran.**

**Key words:** Barrier, Condom use, Qualitative research, Women, Iran.

Sexually transmitted infections (STIs) are a major public health concern in the developing world,[1] especially among women.[2] Socially damaged women (SDW) in Iran include sex workers, drug addicts, homeless, and victims of violence.[3] Changes in sexual behavior in high-risk women have influenced the spread of STIs and have exposed these women to a higher risk of HIV infection.[4]Correct and consistent use of condom is an effective preventative strategy against transmission of HIV infection among sexually active persons who are not mutually monogamous.[5] Promoting condom use and implementing supportive policies play very

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significant roles in reducing the growing trends of STIs and limiting their spread.[6]

Complex personal and social interactions involving contextual, psychological, and personal factors affect condom use.[7] Explicating the potential barriers to condom use represents an important step in promoting an effective strategy for improving its use.[8] Previous studies have demonstrated low rates of condom use in at-risk population in Iran.[9-12] The rate of condom use in injecting drug users has been reported to be around 37%.[10] For female commercial sex workers, this rate was 52%[11] in one study, but only 11% in another.[12] Nearly fifty percent of young men with more than one sexual partner did not use condom; furthermore only one third of drug injection users used condom in their last sexual act,[13] and some indirect evidence indicates a minimal use of protective behaviors among these populations.[14]

Considering the low rate of condom use in this area in Iran, the present study is aimed at exploring the barriers against condom use and the related factors from the perspective of SDW.

## METHODS

Qualitative research methods were used for better understanding of the contextual issues surrounding barriers to condom use among SDW. Qualitative methods can be used to understand complex social processes, to capture essential aspects of a phenomenon from the perspective of study participants and to uncover beliefs, values, and motivations that underlie individual health behaviors.[15] Participants were selected from SDW, defined as drug addicts, homeless, sex worker, and victims of violence. Socially damaged women are highly stigmatized and considered to be a hard-to-reach population. Participants were recruited from two shelters and three harm reduction drop-in centers (DICs) in Tehran. Two focus group discussions (FGDs) and eighteen in-depth interviews were conducted with SDW from February 2013 to May 2013. Each FGD consisted of 8–10 SDW, and interviews lasted for about 70 minutes. The FGDs explored a number of issues such as their perception of STIs, risky sexual behavior and their socio-economic and cultural context, and preventative measures taken against STIs. The semi-structured interview guide consisted of questions to allow participants to fully explain their perceptions and experiences without a previously determined sequence or set of response options.

In-depth interviews lasted between 34 to 87 minutes (average 58 minutes) and in two cases, interviews were repeated to confirm responses given by the participants, to make sure that their replies were in line with the concept emerged based on their feedback. To fulfill inclusion criteria, study participants had to be 15-45 years of age, Farsi speaking, Iranian and residents of Tehran, being sexually active in the past 12 months, and interested in participating in the study. Purposive sampling with maximum variation sampling was used in order to maximize the range and diversity of the sample according to age, education, marital status, imprisonment record and risky behavior. All of the interviews were conducted by a female interviewer in a private room using a semi-structured interview guide consisted of open-ended questions to allow respondents fully explain their own opinions, perceptions, experiences about STIs preventive behaviors such as condom usage. The interviews were carried out in Persian by the first author. Recordings were transcribed verbatim and analyzed consecutively. Consistent with national expectations concerning appropriate remuneration to participants in research studies in Iran, each study participant was given a gift. Data collection and analysis were done simultaneously according to content analysis method. The transcripts were manually coded and grouped into categories to explore the initial themes. The analysis of the data was conducted using transcripts by the first author. The data were further explored, using content analysis, for the identification of recurring themes. Transcripts were read several times and coded, and emergent themes were identified. Theoretical saturation is when repetition and redundancy is observed. Data reaches saturation when subsequent new information tends to confirm existing classification themes and new discrepant cases stop appearing.[16] In this study, theoretical saturation emerged when coding of the eighteen participants was completed.

Extended interaction between researchers and participants and sufficient time devoted to data collection were important for data validity. In addition to main researchers, all other

team members actively participated in all stages of the project. Three randomly selected participants were given a full transcript of their coded interviews with a summary of the emergent themes to determine whether the codes and themes matched their point of view. The participants provided feedback and all confirmed the concepts and themes that were developed by the research team. In order to assess the reliability of the data, seven transcripts of the interviews, codes and categories were rechecked by the study team and a high level of agreements was noted. Disagreements between the researchers were resolved by group discussions. Aside from the research team, results were also checked with qualitative research experts, who confirmed the fitness of the results. In order to ensure credibility of data, the whole process of research such as methods for data collection and analysis, and opinions of supervisors and researchers were systematically collected and submitted for review by a qualitative researcher in the field of high risk sexual behaviors. In order to increase transferability, the researcher documented the steps followed in the research and it was decided that these be saved for other researchers to use for research in future studies. Confirmability was enhanced by taking detailed field notes and making them available for audit checks and verification by researchers experienced in qualitative data collection and social issues. For dependability the raw data and the data analysis process were scrutinised by an external reviewer, namely the supervisor. An audit trail was established to enable others to judge this study for its dependability.

**Ethical Considerations**

Participants were provided with information regarding the purpose and background of the study and were informed that participation was voluntary and that they may withdraw from the study at any time. Participants were promised that all data collected would remain confidential. Interviews were conducted anonymously and without taking photos. Those who agreed to participate in the study were each asked to sign an informed consent form. All interviews were transcribed the day of record. After transcribing, all recorded interviews were destroyed. Scientific research committees of Shahid Beheshti University of Medical Sciences and Avicenna Research Institute as well as Ethics committee of Avicenna Research Institute approved the study.

## RESULTS

Themes are presented in several parts.

**Characteristics of interviewees and FGD participants**

The interviewees' ages ranged from 17 to 43 with the majority being in their twenties and thirties; all of them had at least primary school education. All the interviewees were sexually active. The demographic and behavioral characteristics of in-depth interview participants are shown in Table 1. The focus group participants ranged in age from 15 to 40; 5 participants were married; and the majority of them (12) had middle school education.

All the participants had access to condoms through shelters and DICs. But they presented a spectrum of factors as barriers to condom use. The most common obstacles to consistent condom use among "SDW" included misperception, low perceived sensitivity and self-efficacy and partner objections. Findings are shown in Table 2.

**Misperception**

Based on the analysis of the participants' comments, two subthemes, individual beliefs and inadequate knowledge, have been explored.

**Individual beliefs**

Some participants mentioned decreased sexual satisfaction and physical difficulties as barriers to condom use.

"We had condoms available, but we didn't use them. You know, the sexual contact would be unnatural with condoms. There wouldn't be much pleasure, especially for men." *[P17]*

"Condoms are not good things. They damage the womb, especially in those who don't have much vaginal discharge." *[P2]*

**Inadequate knowledge**

All women in this study knew about condom, but its use rate among them was very low despite having easy and free access to it. Only one of the participants had ever used a condom. This issue was due to inadequate knowledge regarding to condoms, STIs and disease transmission routes. Some women regarded condom only as a contraceptive method; they

believed they did not need to use it during sexual intercourse if they were using long-term pregnancy prevention measures such as intra-uterine devices (IUD) and tubal ligation (TL). For these participants, pregnancy was a more important issue than STIs.

"At first, a man, who I was his *sighe* (temporarily marriage), used it (condom). I told him not to use it because my tubes were closed (TL): "don't bother"." *[P13]*

Although most of the participants had heard about HIV/AIDS and hepatitis, they had inadequate knowledge of STIs, transmission of STIs, and their prevention.

Among some participants, the number of

**Table 1.** Characteristics of in-depth interview participants

| | Age | Education | Marital status | Imprisonment record | Drug abuse | Homeless | Sex worker* | Infectious diseases |
|---|---|---|---|---|---|---|---|---|
| $P_1$ | 31 | Primary School Education | Divorce | No | Yes | No | Yes | No |
| P2 | 30 | Primary School Education | Divorced | No | Yes | No | Yes | No |
| P3 | 35 | Middle School Education | Divorced | Yes | Yes | Yes | Yes | Hepatitis positive |
| P4 | 26 | Diploma | Divorced | No | Yes | No | Yes | No |
| P5 | 42 | High School | Divorced | Yes | Yes | Yes | Yes | No |
| P6 | 34 | Primary School Education | Divorced | No | Yes | Yes | Yes | No |
| P7 | 24 | Higher Education | Divorced | Yes | Yes | Yes | Yes | No |
| P8 | 28 | High School | Divorced | No | Yes | No | Yes | No |
| P9 | 34 | Diploma | Divorced | Yes | Yes | No | Yes | No |
| P10 | 30 | Primary School Education | Divorced | Yes | Yes** | Yes | Yes | HIV positive |
| P11 | 43 | Primary School Education | Divorced | Yes | No | Yes | Yes | No |
| P12 | 40 | Primary School Education | Divorced | Yes | Yes ** | Yes | Yes | HIV positive |
| P13 | 35 | Middle School Education | Widow | Yes | Yes | Yes | Yes | No |
| P14 | 29 | Higher Education | Divorced | Yes | Yes | Yes | Yes | HIV positive |
| P15 | 28 | Middle School Education | Divorced | Yes | Yes | Yes | Yes | Hepatitis positive |
| P16 | 17 | Middle School Education | Divorced | Yes | Yes | No | Yes | No |
| P17 | 18 | Middle School Education | Single | No | No | Yes | Yes | No |
| P18 | 27 | High School | Separated | Yes | Yes | Yes | No | No |

* exchange of sex for money, drugs, or other goods and services
** Two of the drug abuser was injection drug users.

**Table 2.**The most common obstacles to consistent condom use among "SDW"

| | |
|---|---|
| Misperception | Individual beliefs |
| | Decreased sexual satisfaction |
| | Physical difficulties |
| | Inadequate knowledge about: |
| | Condom |
| | Sexual transmitted infection |
| Low perceived sensitivity | Relationship status |
| | Trust and loyalty |
| | Appearance based judgment |
| Low perceived self-efficacy | Lack of behavioral skills |
| | Woman's inadequacy in making decision to use condoms |
| Partner objection | |

sexual partners and the type of sexual relationship were mentioned as the deciding factors in using condoms. Some of them did not feel the need to use condom just because they had limited number of partners or had a superficial sexual relationship, while others thought the only mode of transmission for STIs was through blood and because they did not inject drugs, they were not exposed to diseases.

"Well, I do not put myself at risk for diseases. I have never been injection drug user. Every once in a while I go for a check-up and each time, I have sexual relationship with one person only". *[P1]*

"Common infected syringes cause diseases because syringes enter blood, but an unprotected sex does not cause blood contact." *[FGD1 participant]*

**Low perceived sensitivity**

This theme consisted of subthemes such as relationship status, trust and loyalty, and appearance based judgment.

**Relationship status**

Relationship status was one of the barriers to condom use in this study. Despite knowing their partners' dangerous behavior like being polygamous, homosexual or addicted, some women considered being in a temporary marriage (sighe) or in a long-term relationship to be protective factor for STIs, and therefore didn't use condoms.

"I have been his sighe for 3 years, I don't need to use condom." *[FGD2 participant]*

**Trust and loyalty**

For some participants, trust, loyalty, and partner's honesty were obstacles to condom use.

"Whenever we talked about this issue, he said, "Don't talk about such things. Don't you trust me? Don't you know me? I have trust on him; He has no relationships with anyone other than me." *[P17]*

**Appearance base judgment**

Among some participants, judgment based on appearance was the reason to use or not to use condom.

"A prestigious person doesn't have HIV. They value themselves too much to have sexual relationships with just anyone." *[P17]*

"I have had sexual relationships with different people. I rely on their character. If they look prestigious, it is clear they are really good men, and do not use drugs. That's why I did not use condom with them. If anyone was supposed to worry and use condom, it was them not me, because they didn't have any risky behaviors." *[P10]*

**Low perceived self-efficacy**

This theme includes two subthemes: lack of behavioral skills and lack of power to make a correct decision to use condom. The women in this study did not have protected sex because of fear of being branded as sex worker, or having inadequate behavioral skills or low self-esteem, or fear of losing emotional and financial support of their sexual partners. These women feared if they use condom, their partner would abandon them.

"I recommend using condom, but if my partner doesn't want to use it, I still have sex with him to avoid feeling lonely as well as for the gifts he buys me." *[P1]*

"We cannot speak to men about using condoms, they would think: "She is a professional!" or "She certainly is a prostitute because that she offers it (condom). " They can't be deceived or forced to use condoms. *[P10]*

"I would have suggested using condom, but I didn't take it seriously because he supported me both financially and emotionally." *[P9]*

"I have had sex with some men the way they wanted, because I had to make money for my addiction. Addiction isn't predictable. It's not like food such as lunch or dinner. The more you smoke drugs, the more you crave for them. " *[P8]*

**Partner objection**

Partner objection or unwillingness to use condom was another barrier to condom use among SDW. Partner objection for using the condom was expressed by 6 participants.

"Yeah, men don't like to use it. They say it is artificial and plastic and they don't have real pleasure. They must make something that increase pleasure of relationship. " *[P1]*

## DISCUSSION

SDW participating in this study included injection and non-injection female drug addicts, sex workers, and homeless. All the participants were sexually active. This research illustrates that misperception, low perceived sensitivity and self-efficacy, and partner's objection were the main barriers to condom use.

Most of these women were aware that proper condom use is an effective preventative measure against STIs, but in practice, the majority of participants (16) had unprotected sex despite the free and easy access to condom at harm-reduction DICs. Two of them had acquired HIV infection through unprotected sex. In the Middle East, among all people who recognize the protective effect of condoms against HIV transmission, only a few actually use them, of whom, even fewer use them consistently. Even in high-risk groups for which using condom is a priority, the rate of condom use is low.[17]

For some participants, pregnancy was a more pressing issue than STIs. Their rationale for having unprotected sex was the use of long-term pregnancy prevention measures such as Intra uterine device (IUD) and tubal ligation (TL). Saura Sanjaume reported that in young population, the risk of pregnancy has the most influence on adopting protective measures.[18] These findings suggest that the current condom use mass campaign efforts in the country have a greater potency to restructure a repertoire of cognitive sexual thoughts of the high-risk groups and enable them to appreciate the sexual benefits of condoms.

Half the participants identified interference with pleasure and physical difficulties as barriers to condom use. One study on Iranian female sex workers showed although some clients were inclined to use condoms while engaging in sexual contact, the majority preferred contact without condoms.[13] In the current study, the main reasons for detesting condom use were decreased sexual satisfaction inconvenience for anal contact, and dislike and fear of using condom. Another study on IV drug users demonstrated, despite good access and availability, condom use to be very low among drug addicts in Tehran, presumably in order to avoid decrease in sexual sensation. [19] Decrease sexual satisfaction has also been mentioned as an influential factor in various studies both in Iran and other countries. [9, 20] Sunmola research for condom use reported decreased sexual urges and satisfaction, boring sexual experience, inadequate sexual foreplay, feelings of distrust by ones sexual partner, and health problems such as itching, skin irritation, and hurting, as the barriers for condom use.[20] Additionally, condoms may burst, leak fluid, and slip off. Educational and counseling programs may be able to target this attitude and emphasize on the benefits of condom use particularly for high-risk groups.

The present study revealed that lack of proper risk perception is a common problem among SDW, which prohibits them from using condoms on a regular basis. In some participants, relationship status was one of the barriers to condom use; they exposed themselves to diseases merely because their sexual relationship was legal. Jie reported that China's female sex workers (FSWs) often did not use condoms while being intimate with their partners or clients.[21] Having a regular partner was frequently reported as a psychosocial barrier to condom use.[22] Some participants had were afraid of losing the male partner if they had insisted on condom use during sex, while some other did not use condom in order to foster trust. Misperception of safety led to improper risk assessment, and a false sense of trust and safety was considered to be the main reason for not using condoms regularly.[23] Knowing and trusting a client has been cited as a key barrier to condom use in China.[21] One of the most important barriers to condom use in Lotfi study was the perception of trust, commitment and loyalty established by marriage that is in accordance to legal and religious requirements.[23] Having a relationship with someone for a long time builds trust, which leads to non-condom use.[22] Research among heterosexuals, particularly among young women, has demonstrated that trust is central in defining the meaning of sexual involvements. The nature of a relationship and the degree of familiarity as well as the means of familiarity, play key roles in determining whether condoms are used.[24] To address this issue, women should be systematically educated that trust cannot protect them from contracting STIs including HIV.[21]

Among some participants, judgment based on appearance was the reason to have unprotected sexual relationship. Several studies have identified social influences, such as sex venue [25, 26], occupational characteristics and social support as important determinants of unsafe sex among FSWs.[21] Such women didn't imagine prestigious men could expose them to STIs and didn't feel any need to use protection. Studies repeatedly have shown that young people assess the disease risk of a potential partner by how well

they know their partner socially, their partner's appearance, or other unreliable indicators.[27, 28]

A study in Nepal reveals FSWs were relaxed and tended not to use condom with apparently healthy, young, educated and wealthy clients.[29] In Jie study FSWs tended to make decision on condom use based on their own stereotypes and personal assumptions about their partners and young people did not use condoms with a partner they perceive to be clean. This indicates that greater effort should be made in prevention campaigns to de-link STIs with dirtiness. The message should be: "anyone can get STIs, farmer or business man, prostitute or professor".[21]

SDW participating in this study were unable to make decision about having protected sex because of emotional and financial needs, inadequate behavioral skills including low self-esteem, inability to say no, addiction, and fear of loneliness and homelessness. Lack of authority to make decision on the sexual contacts and use of condom was reported as the reason for having unprotected sex by 16 participants. Lack of communication skills such as ability to say no and lack of negotiation skills regarding condom use were highlighted as the main obstacles to its use.[23]

Perceived lack of control in using condoms, as well as low self-esteem was also mentioned as other major reasons for having protected sex. Financial needs and lack of negotiation skills are considered two major factors that discourage FSWs from using condoms with clients, even though they have a good knowledge about HIV.[21] The desire to make more money can lead to a significant difference decision making regarding condom use.[30] In this context, the negotiation skills for condom use are crucial, as clients tend to be willing to pay more for intercourse without protection.[21] In the present study, drug and alcohol abuse are among the most important factors that reduce the perceived risk of STIs; which could be the result of a sense of hopelessness caused by addiction, as well as the individual's inability to make timely and appropriate decisions.[31] In some instance, women might believe not using condom upon their main partner's request in order to obtain food, shelter, money, or drugs outweigh the advantages of protection it provides.[32] Drugs and alcohol cloud decision-making ability; women under their influence may be less able to insist on condom use and are more likely to engage in unsafe sex.[33] Although the causal relationship between drug and alcohol use and safe sex behaviors remains unclear, women under the influence of these substances may tolerate sexual relationships that would be unacceptable to them if they were sober.[32]

In this study nearly one third of women identified partner objection and unwillingness as the obstacle to condom use. Findings of other research support the view that decision making about condom use is partner-specific. [23, 34]

**Strengths and limitations**

Due to the socially sensitive issues with in-depth interviews cannot result in accurate information; a combination of focus group discussions and in-depth interviews would be the strength of present study.

Several limitations were recognized in our study. The primary limitation is that SDW are highly stigmatized, and therefore considered to be a hard-to-reach population. In case of reaching these women, due to the sensitivity of the research topic, women did not cooperate appropriately with the research team. Therefore the researcher was present at the centers for a longtime and held training and consulting classes and treated the SDW. Due to long-term interaction between the researcher and women, participants were willing to participate in the research. Another limitation of our study was participants full cooperation during the interviews because of addiction to drugs and severe dependence on smoking. In addition in some cases recalling painful experiences was an obstacle to interviews. The interviews were conducted in several stages for convenience and satisfaction of participants and smoking was permitted during the interviews.

## CONCLUSIONS

Most women are not aware, or have incorrect understanding, of the dangers of having sex without condom. This is a detrimental factor in adopting healthy behaviors. People will opt for protective measures if they perceive they are at risk of acquiring a disease with serious consequences, and believe preventative measures available to them would reduce their susceptibility

to the disease and/or the severity of the disease. Therefore, people can successfully change a behavior if they feel threatened by the consequences of that behavior (as perceived susceptibility and severity), and believe such a behavioral change will bring about positive and valuable outcomes. They need to feel efficient and worthy in order to overcome obstacles. Training and counseling are essential to comprehend danger, change the views of SDW, and work out some solutions to the aforementioned obstacles. Some of these problems can be avoided by planning and precisely reviewing the programs at hand by authorities in charge.

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