Barriers to condom use

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ABSTRACT

Objective To identify barriers to condom use.

Methods Data were extracted through MEDLINE from papers published between 1993 and 2007. Surveys, reviews, clinical studies and comments were included in this review. The impact of cost, moral, social, personal and psychological factors were taken into consideration.

Results Several factors were associated with non-use of a condom during sexual intercourse. Their cost often posed a barrier to condom use for the poor, even in developed countries. In many communities, moral values, ethnic and religious factors also played a role. Among other social factors, gender inequality, lack of a dialogue among partners with regard to condom use, and the stigma attached to the condom could all lead to unprotected sexual intercourse. Personal factors such as aversion to the condom, consumption of alcohol or use of drugs prior to sexual intercourse, and anxiety and depression all were negatively associated with condom use.

Conclusion Their cost evidently poses a barrier to the use of condoms by the poor. Beside social stigmas and personal reluctance, prevailing moral norms and religious interdicts also adversely affect use of these devices in many communities. Because of their disastrous consequences in the domain of public health each of these barriers must be effectively addressed.

KEYWORDS Unprotected intercourse, Social factors, Psychological barriers, Morality, Ethnicity, Religiosity, STIs, AIDS

INTRODUCTION

The condom, of which exist both a male and a female type, has a dual function. It is a barrier method of contraception; it is also the most efficacious available means for reducing the risk of transmission of agents of sexually transmitted infections (STIs), including HIV. Male condoms are made of latex, polyurethane, or synthetic elastomers. On the contrary, the female condom, which is available under various trade names, is made only of polyurethane.

Condoms have gained more importance for preventing the spread of AIDS. Yet, a large section of the population, ignoring the risk of STI-transmission, still has unprotected sexual intercourse. With a view to finding out why, a search of MEDLINE database service covering the years 1993–2007 was undertaken using ‘condom use’ and ‘non-use of a condom’ as key words in an attempt to identify factors associated with the latter entity. The search outcome included reviews, surveys, clinical studies, and comments. Identification of factors involved is important for the promotion of condom use as a preventive measure against STIs and AIDS in the community.
COST AND SCARCITY

Does cost really represent a barrier to condom use? In many developing countries, male condoms are freely available from public health facilities. More than 30% of groceries and kiosks—outlets commonly found in low-income residential areas—stocked free-condoms in Zambia. Users’ access to condoms was greater for poorer compared to wealthier respondents because of their residential areas within a ten minutes walk of a condom outlet, thus eliminating socio-economic inequality in condom access.

However, many African-Americans living in the USA were unable to purchase condoms due to a lack of income since 29% of them lived in poverty; they thus engaged in unprotected sexual intercourse. The socio-economically weaker section of the urban population in other industrialized countries seems to face the same problem. The female condom was too expensive for 77% of the rural Zimbabweans while the male condom was available free of cost from the health centres. As a consequence of this discrepancy, re-use of female condoms was once thought of or recommended, but this did not materialize because of the risk of infection involved with this approach.

Condom use was significantly less frequent with non-commercial sexual partners who complained about the scarcity of condoms in Cambodia. In Andhra Pradesh, India, condoms could be obtained for free from non-governmental organization facilities or purchased from pharmacies at a cost of 10–20 rupees (0.18–0.36€) per pack. But because of the scarcity of free condoms and their insufficient income to purchase those being sold, illiterate street-based female sex workers (FSWs) aged >30 years reported that they had no access to them.

The low purchasing power of the rural mass, the cost of condoms, and the rural-urban disparity in availability greatly interfere with condom use among the socio-economically weaker section of the rural population in many countries.

MORALITY

In every society, people have their own moral, religious and ethnic doctrines that have not only reinforced their social fabrics but, due to prolonged observance in the community, also have pervaded the psychosocial environment of the individual. Obviously, an intervention (condom use) altering their age-old natural reproductive practices may be opposed or rejected by the individual or the community though people deeply feel the need of resolving socio-economic constraints associated with the explosive growth of the population.

Could tenets of morality, religion and ethnicity of a particular community be done away with for condom use so easily? Measures for population control imposed on Malawians by the national government seemed to have brought about a negative effect on condom use because they did not take the moral aspects sufficiently into account. University students in San Antonio, Texas, expressed regrets for their decision to engage in sexual activity on the ground of having transgressed their moral rules. The denial of moral norms when promoting condom use led to avoidance of use during sexual intercourse among drug users in Houston, Texas. Normative beliefs and subjective norms have been shown to adversely affect lifetime condom use, current condom use and self-efficacy in condom use. Consequently, they stand as a barrier to the prevention of STIs. African women often submit to unsafe sex because of their inability to reconcile their wish that a condom be used with norms that demand modesty and submissiveness in the contraceptive decision-making process. The stigma thus attached to condom use in a given community may deeply influence people; it will take time to have it wiped out.

Education and gender influenced condom use self-efficacy, which in turn influenced condom use at the last sexual intercourse and with the main sexual partner, among Latinos living in Houston. Condom use self-efficacy and sexual risk behaviour differed between Latino men and women.

African-American and Hispanic men in Houston expressed difficulty in using a condom when having sex, but the pattern for homosexual, heterosexual and bisexual men varied across race or ethnicity. Homosexual African-American men felt least difficulty while homosexual white men expressed most difficulty. For homosexual men, a considerable difference was found across race or ethnicity in the proportion of partners who never or rarely disagreed to use a condom, with Asians disagreeing least and African-Americans most. However, the frequency of condom use and the difficulty encountered were similar for both male and female partners of the same racial or ethnic group. This indicates that ethnic
factors may directly or indirectly be linked with non-use of a condom.

RELIGION

Religious ideology influences condom use. The measure of religiosity (group affiliation, attendance at religious services, attitudes, perceptions of negative sanctions and adherence to sanctions) was found to be associated with sexuality. Religious behaviour is a strong predictor of sexual behaviour. Many aspects of religiosity are associated with general sexual attitude.

Since its very inception, the Roman Catholic Church has forbidden the application of contraceptive measures because it considers that such interference is a transgression of divine law and a sin against nature. In the encyclical of Pius XI *Casti Connubii* (1930) and that of Paul VI *Humanae Vitae* (1968) birth control was again categorically rejected. In spite of their difficult application and poor efficacy, only the so-called ‘natural methods’ (e.g., rhythm method, Billings method) are allowed. The use of contraceptives is prohibited whatever the circumstances. This also applies to the condom even when one intends to use it, not to prevent pregnancy, but to avoid a fatal infection such as HIV/AIDS. For instance, the use of a condom within the marital relationship when one of the spouses is HIV positive is considered sinful.

This interdict has had the direst consequences with regard to the implementation of AIDS prevention programmes among Catholics living in developing countries. Elsewhere, the moral arguments for the position of the Church have suffered general erosion. Many Catholics indeed regard the reiteration of the traditional prohibition of birth control by the successive Popes as a simple exercise of authority and do not abide by it.

An obvious different interpretation developed within Christianity as, with few exceptions (e.g., the Mormons), the Protestant churches emphasised birth control, basing their views on their Puritan tradition and responsibility founded on a Christian social ethic.

The Islamic law states that children are the gift of Allah. Some Muslims believe that they must have many children and they may oppose condom use. However, according to Islamic faith, children have rights to education and future security, which entails that their number may have to be limited and thus that birth control is licit. Condom use is prohibited neither for prevention of unintended pregnancy nor for that of HIV/AIDS. Moreover, Muslims must also abide by the Islamic moral code that forbids adultery, pre-marital sex and homosexuality to reduce the risk of HIV infection.

Hinduism flows from the Veda and Vedanta philosophy. Hindus are allowed to use a condom for contraceptive purposes as well as for protection against transmission of HIV/AIDS. Also Buddhism, Sikhism, and Jainism have made theirs this principle. Among Hindus, Muslims, Buddhists, Sikhs and Jains, husband-wife communication, gender roles, access to contraceptives and traditional family values have more effect on condom or other contraceptive use and fertility than theological or religious barriers.

Judaism requires husbands to fulfil their wives’ sexual needs, separate from their duty to procreate. It also urges men, not women, to procreate and forbids men from masturbating. Thus, the Judaic moral code does not forbid women from practising contraception. But based on the biblical phrase, ‘he shall leave unto his wife and they shall become as one flesh’, the Jewish tradition strongly mandates unimpeded physical contact between the man’s semen and the vagina. Thus, the strict avoidance of a barrier between the couple obviously applies to the condom. However, the vaginal diaphragm and the cervical cap are acceptable, since they do not interfere with direct contact.

SOCIAL FACTORS

The individual can hardly shake off social constraints and, hence, may be confronted with internal conflict or opposition from the society when intending to adopt a method, which is prohibited in the community. Women reported that the relationship with their partners had been difficult because of the absence of dialogue about sexual matters and men always had the final word. Despite being informed about AIDS, women did not use preventive measures in their steady relationship because they did not wield decision-making power. In various communities (e.g., Brazil, South Africa, migrant Mexicans), women—and frequently men, as well—involved in a stable, ongoing sexual relationship admitted avoidance of condom use due to fear of being suspected of infidelity that could lead to separation of the couple. The condom negotiation scenario may be very risky.
for a woman when she is charged with infidelity. The violent behaviour of the male partner within the relationship predicts a more coercive response to a woman’s condom negotiation, with the allegation of infidelity on the part of the woman. Many women at high risk for HIV infection face resistance, and in some cases violence, as a response to their requests that a condom be used. Evidently, this scenario suggests that domestic violence acts as a barrier to condom use during sexual intercourse.

Some people also associate condoms with promiscuity probably because of their extensive advertisement in AIDS educational programmes in the media, especially on the television. As a result, both women and men reported that it would be difficult to introduce a female condom in the marital relationship due to the stigma attached to the condom in general, in rural Zimbabwe. Condom use was less frequent in the Middle East in spite of increasing awareness about STIs and AIDS. One of the reasons was the residual social stigma attached to the condom13. Youths may abstain from condom use during sexual intercourse with both casual and steady partners. Being a woman, having less schooling, being jobless, and having a low per capita family income were factors related to non-use of a condom among young people having sex with steady partners. A history of alcohol use, sexual debut at 9–16 years of age, inadequate knowledge of the fact that AIDS is treatable, and bereavement related to violence in sexual encounters with casual partners, were also associated with non-use of a condom.

The social dimensions of masculine sexuality, pleasure, eroticism and emotional aspect of men’s lives influence condom use. Men’s emotional fulfillment with attainment of satisfaction through direct penile-vaginal contact and ejaculation during natural intercourse is an obstacle to condom use. Some men perceive prolonged sexual intercourse without a condom as a sexual prowess in the domain of masculinity and seek to preserve this manly skill by avoiding condom use14.

Mutual trust and love usually form a scaffold for partners in the relationship. One major barrier to condom use among urban youth in Mozambique was their belief that they did not have to use condom in the steady relationship built on love and trust, which provide a sense of immunity to infection. Their perception of pleasure, lack of accurate information, lack of sex education and gender disadvantage further contributed to their non-use of a condom15. Among FSWs in Nyanza, Kenya, condom use was fairly frequent (75%) with clients, but rather infrequent (<40%) with regular partners, probably because of built-up trust16. Among aboriginal people, there is some evidence for a negative association between condom use and having a steady sexual partner. The negative association for condom use was also observed between the white male and the native Alaskan female sexual partner17.

Socio-cultural concepts and beliefs about sexual conduct influence condom use in the marital relationship in India. The underlying holistic health belief and cultural belief about transmission of HIV are likely the cause for avoidance of condom use by married couples18. In Mumbai, young men indicated that lack of privacy in stores and the social stigma associated with condoms were the most significant barriers to their use. In southern India, also other barriers were identified, namely, the complexity and the stigma associated with condom negotiation, the perception of HIV altered by infected peers showing little concern about protecting others, the linking of condom use to gender and sexual roles, and the inconvenience or lack of appeal of having to use the device19. In sub-urban Andhra Pradesh, 55% of men who had sex with men did not use a condom at least once. Married men had unprotected vaginal or anal intercourse with their wives as they did not feel the need to use a condom with the regular sexual partner. But about 25% of them had anal intercourse with men and also vaginal or anal intercourse with other women without a condom20.

Social factors such as the high prevalence of rape, the unfavourable economic position of women, and the inability to insist on condom use made South African women unable to negotiate the timing of sexual intercourse and the conditions under which this occurred. In Thailand, social and cultural factors, such as the life style, prostitution and the brothel system, and the stigma attached to AIDS, were barriers to condom use and implementation of other interventions for reduction of the risk of transmission of STIs/AIDS21. Also in Brazil and in Kenya, women faced social and cultural barriers to negotiate condom use with sexual partners.

Mexican women living in Atlanta, Georgia (USA), or Mexico expressed a marital ideal characterised by sexual intimacy, communication, joint
decision-making, and sexual pleasure but not by willingness to use a condom as a HIV preventive strategy.

PROSTITUTION

Forty percent of FSWs in Tijuana, Mexico, were single mothers supporting children. They often faced risks of physical assault, STIs, and unintended pregnancy, for good income from Mexican and foreign clients. Most clients did not want to use a condom and offered additional money for unprotected sexual intercourse. The FSWs themselves did not like to use a condom because they perceived it as uncomfortable. Most FSWs did not negotiate condom use, had little knowledge about how to use it properly, and were reticent to report their own unsafe sexual practice.

In Mainland China, the street-FSWs working in isolation were poor and less likely to use condoms with their clients. The major barriers to condom use were economic deprivation and threats of violence from clients. For female entertainment workers (FEWs) working in entertainment venues, drunkenness of clients, the rate-settlement mechanism and familiarity with clients posed a barrier to condom use. Among FEWs in Shanghai, the prevalence of unprotected sex varied by individual characteristics across different settings where commercial sexual activity took place, and by the FEWs’ relationship to pimps or establishment owners. The lack of knowledge about HIV transmission, poverty, clients’ refusal or coercion and control by pimps or establishment owners acted as barriers to condom use. These women were also suspicious about the Government’s programmes for prevention of STIs/AIDS.

PARTNER CHARACTERISTICS AND TYPE OF RELATIONSHIP

Partner characteristics influence condom use among young men living with HIV. About 34% of polygamous and 28% of monogamous youth engaged in unprotected sexual intercourse in the USA. Monogamous youths were most likely to have sex without a condom with HIV positive regular partners. Polygamous youths were most likely to have unprotected sexual intercourse with HIV positive partners irrespective of whether the partner was regular or casual. For polygamous young men living with HIV, unprotected sexual intercourse with new partners was not influenced by risk levels, thereby indicating their careless attitudes towards the safeguard of the new, HIV negative, partner. About 29% of HIV positive men and women engaged in unprotected sex in San Bernardino, California. The most frequent reason reiterated by them was the partnered-related and hedonistic motive.

Although adolescent boys initiated sexual practice earlier than girls in urban Tijuana, girls were more likely to have unprotected sexual intercourse because of stereotypical gender roles and communication barriers about condom use.

An association has been observed between the type of relationship and risky sexual behaviour (e.g., unprotected sexual intercourse) in incarcerated women in Rhode Island, USA. Their decision to use a condom or not depended on whether they were to have sex with someone they considered to be their main or only a casual partner. In those women, pregnancy was negatively associated with the intention to use a condom with the main partner. Binge drinking and believing in the role of chance in determining one’s health were negatively associated with the intention to use a condom with the casual partner.

Over 17% of male students and 15% of female students in certain American public universities admitted to have dissuaded their partner of using a condom, and about 30% of students reported that their sexual partners had attempted to dissuade them. Despite their claim that frequent attempts to dissuade partners from using condoms occurred in the committed relationship, condom dissuaders did show evidence of engaging in other high-risk sexual behaviours.

Individual capability often dominates social or sexual activities among adolescents. Adolescents having more power than their partners in the domain of emotional intimacy are more likely to get their way about condom use than adolescents having less power in this domain. Young men reported greater power in the area of emotional intimacy and decision-making than young women. However, the gender was not related to getting one’s way about condom use. Also in the intimacy of the sexual relationship, peers’ pressure affecting condom use could not be ruled out.
Thus, various social factors may be associated with unprotected sexual intercourse. Fontes and Roach found that, in the United Kingdom, the likelihood of unprotected sex is significantly associated with a greater age, the absence of formal sex education, a lower age at sexual debut, and a greater number of sexual partners. The association of sex orientation and relationship status with unprotected sexual intercourse was confounded by the number of sexual partners.

**PERSONAL FACTORS**

Individual perception, notion or constraint is likely to influence condom use. In Zambia, having a sexual partner from the same community was associated with non-use of a condom. In sub Saharan Africa, perceived lack of efficacy and condom related problems were barriers to condom use. In South Africa, the negative attitude towards condoms and other contraceptives was consistently associated with the probability of decreased free condom procurement from public health facilities. In Nigeria, the major barriers to condom use experienced by truck drivers were that the condom reduced their sexual satisfaction and hindered their sexual interest. In Sao Paulo, Brazil, most HIV positive, heterosexual men used no condom when having sex because they were unaware of their HIV positive status until they were tested due to illness. In Kenya, men who had coitus with sex workers refused to use a condom under the pretence that the condom was unpleasant, defective, harmful, unnecessary, and too hard to use.

In New Zealand, one out of four sexually active teenagers reported non-use of a condom because they did not think either they or their partner had an infection, and a similar proportion did not use a condom because they applied other contraceptive measures. The most common reasons adduced for non-use of a condom by South African university students were ‘I do not have the AIDS virus’ and ‘I thought I was safe’, apparently indicating their low perceived susceptibility behind avoidance of condom use. Common reasons for non-use of a condom among drug users in Rhode Island, USA, included a lower perceived risk of contracting STIs, and a negative attitude towards the effect of a condom on pleasure. Thus, individual perception of risk or pleasure often affects condom use.

Both average coital frequency and average non-use of a condom increased among adolescent women during 27 months of longitudinal follow-up in Forth Worth, Texas. The increased non-use of a condom over time was primarily a function of increased coital frequency; a higher level of relationship quality (i.e., ‘This partner is very important person to me’) was from the onset associated with increased non-use of a condom.

**USE OF OTHER CONTRACEPTIVE METHODS**

The temporal rise in non-use of a condom was significant among users of injectable depot medroxyprogesterone acetate as compared to oral contraceptive (OC) users.

Use of OCs often posed a barrier to condom use among adolescents in Forth Worth. Only 45% of coital acts were associated with both OC and condom use. Over one-fifth of sexual intercourse was unprotected. Dual use of the OC and barrier contraception remained an elusive goal. Concurrent missed pills and non-use of a condom increased the risk for pregnancy and contracting STIs even among stable OC users.

**CONDOM-RELATED PROBLEMS**

Discomfort (e.g., tightly fitting condom, vaginal irritation of women) was reported by young men who also mentioned loss of sensation, and frequent condom slippage during sexual intercourse. Finding the right kind of a condom was not always easy for them. Discomfort was also associated with less motivation to use a condom. True rubber allergy can also occur, but is rare. The problem can be solved by switching to plastic condoms. If the allergen should be the lubricant, for instance nonoxynol-9, one may resort to condoms not lubricated with this spermicide as it does not increase the contraceptive efficacy and may augment the risk of HIV transmission.

**SUBSTANCE USE**

Acute alcohol consumption by college students significantly predicted their perceived likelihood that they would have sexual intercourse without a condom. Although condoms were available free of...
cost to the public, about 20% of South African men did not use them when having sex. Alcohol consumption and use of another modality of contraception were associated with unprotected sex.

A feeling of emotional closeness has often been reported to be associated with the consumption of the drug Ecstasy (methylene-dioxy-methamphetamine; MDMA); some have also mentioned an increased sexual arousal and some, in particular gay and bisexual females, have used MDMA specifically for sexual enhancement. The sexual risk taking behaviour -having multiple sexual partners and engaging in sex without a condom- was prevalent among persons having sex during MDMA episodes.

Among adolescents in Rhode Island, substance use and non-use of a condom use were significantly more frequent with casual sexual partners than with main sexual partners. The regular use of alcohol, tobacco, or cannabis by adolescents in Scotland had a negative impact on condom use regardless of their gender and social background. Another study identified use of alcohol and marijuana as negative predictors for intention to condom use among the military personnel in the USA. Substance use was significantly associated with non-use of a condom among HIV positive youths in Detroit.

**Psychological Factors**

Severe depressive symptoms affecting adolescent males were significantly predictive of substance use and non-use of a condom or other contraceptive at last coitus, in a nationwide sample of middle and high school students in the USA. Social anxiety among gay and bisexual youths was found to be associated with unprotected anal intercourse.

Beliefs regarding sexual sensation and STIs or pregnancy prevention affected Central American women’s attitudes towards condom use. The degree of mutual trust between sexual partners also affected attitudes towards the female condom.

A depressed mood, female gender and unemployment increased the likelihood of engaging in unprotected sex among young people in Australia.

**Conclusion**

Ever since the condom has been introduced as a barrier method for contraception, some people have considered the device only for contraceptive purpose, not for protection against STIs. Campaigners promoting condoms should consider this improper perception and orientation affecting many people when propagating its use in the context of an AIDS prevention programme. The barriers to condom use must be highlighted to make people overcome them. Education will help groups at risk to understand the necessity of using this device to avoid contracting STIs, including AIDS.

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