BARRIERS TO CONDOM USE AS A HIV/STI RESISTANT PREVENTIVE HEALTH BEHAVIOR BY TURKISH WOMEN

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Abstract

Barriers to Condom Use as a HIV/STI Resistant Preventive Health Behavior by Turkish Women

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By understanding the obstacles faced by women in the world’s multicultural environments, we can provide them with strategies in which they would be able to negotiate safe sexual practices. Through this understanding we can have a positive impact on efforts to slow the spread of Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Infection (STI).

This manuscript reviews literature involving Sexually Transmitted Infections, including HIV/AIDS among women in Turkey. The Health Belief Model (HBM) will be used to help focus negotiation strategies for Turkish women to adopt proven successful preventive health behaviors, such as the use of condoms. In addition, it explores the state of HIV/STI knowledge and educational needs within the sexually active Turkish population. Finally, this review describes a successful marketing campaign designed to promote increased acceptance and use of condoms by Turkish men, within the framework of the traditionally Muslim Turkish culture.
Key Words: Muslim, Turkish, Turkey, condom, women, violence, preventive health behaviors, HIV/AIDS, barriers, Health Belief Model. 

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Dedication

To my Mother and Father, who loved me enough to let me follow my
dreams that were so different from their own,
to become who I am.
Barriers to Condom Use as a HIV/STI Resistant Preventive Health Behavior by Turkish Women

Introduction

Human immunodeficiency virus/sexually transmitted infection (HIV/STI) prevention and reproductive health interest has developed in terms of women's ability to negotiate safer sexual practices. Sexually transmitted infections (STIs), including infection with the human immunodeficiency virus (HIV) are an ever-growing problem for women (Pulerwitz, Gortmaker & DeLong, 2000). By understanding the barriers to condom use faced by women within multicultural environments, in this case Turkey, health care providers may provide women with effective strategies with which they may be able to successfully negotiate condom use with their partners. Using a culture specific approach, health care providers can have a positive impact on efforts to slow the spread of HIV and STIs among the Turkish population.

Women constitute just under half of the 39.4 million adults living in the world with HIV. Women account for 57% of the adult HIV infections in Sub-Saharan Africa (UNAIDS, 2004). Traditional HIV and STI prevention efforts have consistently focused on two main messages: 1) practice mutual monogamy and 2) use of condoms (Go et al., 2003). However, limits on women's economic and social freedoms lead to a powerlessness to engage in HIV/STI preventive health behaviors (Gupta & Weis, 1993; Worth, 1989; Zierler & Krieger, 1997). For women, powerlessness, when combined with the potential risk of intimate partner violence, can constrain them from taking the desired,
available, or appropriate preventive health behaviors to protect themselves from the risk of potential STI and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) infection. Under these conditions, an environment exists where women are not able to effectively negotiate condom use with their intimate sexual partner, monogamous or other and thereby face the recurring risk for exposure to and infection from STIs including HIV.

In 2003, the population of Turkey was estimated to be 68.1 million people (U.S. Department of State, 2004). Twelve million of those live in Istanbul. Sixty-seven percent of the Turkish population is under 35 years of age. The age of the population is conducive to the spread of STIs and HIV infection (Aral, 1999 as cited in Özarmagan & Bingham, 2001). Ninety-eight percent of the population of Turkey is Muslim.

Traditionally, the religious beliefs, secular laws and the social norms of such a society do not permit sexual contact outside of marriage. These rules in practice have traditionally only applied to the female population. In Turkey, the women with whom Turkish men have extramarital sexual contact are generally commercial sex workers (Özarmagan & Bingham, 2001). Because of its' geographic location, Turkey has been directly affected by the collapse of its' neighboring state, the former Soviet Union. As a result of that now defunct nation's political and economic collapse, many Russian and Romanian women moved to Turkey for brief interludes of prostitution to supplement incomes to support themselves and their families. This has
now turned into a substantial business in Turkey (Özarmagan & Bingham, 2001).

Statement of Purpose

To determine the barriers to condom use as a preventive health behavior by Turkish women, an extensive search of the professional literature was made. Using queries of the professional literature search engines, Medline/PubMed, ProQuest, and the Cumulative Index to Nursing and Allied Health Services (CINAHL) to terms: Muslim, Turkish, Turkey, condom, women, violence, preventive health behaviors, HIV/AIDS, barriers and Health Belief Model. A total of seven English language references, were identified which were deemed appropriate for this review.

Although Turkish language articles of interest were identified during the literature search, English translations of those works were not accessible to this writer. Basic demographic statistics regarding HIV/AIDS in Turkey were not available from standard sources such as UNAIDS, where no estimates have been made from sufficient data for the last six years (UNAIDS, 2003). Even in the annual report of the U.S. Agency for International Development, 2004 HIV/AIDS, demographic data was not available for Turkey (USAID HIV/AIDS, 2004).

Theoretical Framework and Model

The Health Belief Model (HBM), as described by Brown (1999), provides a theoretical framework from which researchers may propose and evaluate strategies that may enhance the occurrence of a known preventive health behavior. The theory identifies and describes specific factors influencing the likelihood that a specific (desired)
preventive health behavior may occur in the face of significant identified barriers to the desired behavioral change. By specifically addressing ways to reduce or overcome these identified barriers, health care providers can develop directed strategies designed to increase the probability that the desired preventive health behaviors will be adopted and practiced in the target population.

The HBM as originally developed by Godfrey Hochbaum, Stephen Kegels and Irwin Rosenstock (1952), is a theoretical framework that could explain and predict preventive health behaviors. The model focuses on the relationship of health behaviors to practices and utilization of health services. In recent years, the Health Belief Model has been revised from its’ original design to include “general health motivation” for the purpose of distinguishing illness and sick role behavior from healthy behavior. Since 1952, the HBM has been generally regarded as the beginning of systematic, theory-based research in health behavior (Brown, 1999).

The original HBM factors influencing the likelihood of the occurrence of a preventive health behavior were (1) a person’s perceived susceptibility (perceived vulnerability to a disease or the risks of contracting it); (2) perceived seriousness (severity or the consequences of contracting a disease); (3) perceived benefits (positive results of steps taken to avoid contracting the condition); and (4) perceived barriers (negative aspects of undertaking health behaviors such as disapproval, rejection, cost or threat of violence). Two other concepts, motivation and confidence, have since been added to the original Health Belief Model construct. Motivation refers to
beliefs and behaviors related to the state of general concern about health (Gözüm & Aydin, 2004). In 1988, Rosenstock et al. added self-efficacy to the list of variables that predict behavior (as cited in Gözüm & Aydin, 2004). Self-efficacy introduces the concept that an increase in perceived confidence in executing a behavior will result in an increase in the positive health behavior occurring (University of Twente, 2004).

Review of the Literature

In their examination of how marital violence affects a woman’s ability to protect themselves from HIV/AIDS, Go et al. (2003), conducted in-depth interviews and focus groups of both men and women in selected slums of Chennai, India. Their qualitative study showed the existence of community “gender norms” that “sanction domestic violence” and interfere with adopting HIV preventive behaviors. They reported as part of the conclusions of the study, that given the choice between the immediate threat of violence and the relatively hypothetical risk of HIV, women would often resign themselves to the sexual demands and indiscretions that may put them at risk of HIV infection (Go et al., 2003). This reassessment by women of the perceived seriousness or risk of theoretically contracting HIV, when compared with the stronger immediate threat of violence directly diminishes the probability of a woman taking steps to protect herself (with a condom) from the perceived relative risk of HIV. This fact is consistent with the principles set forth in the Health Belief Model. To be successful, AIDS prevention interventions must incorporate gender relative social contexts in settings where husbands strictly
enforce their locus of control, sometimes through coercion or violence. Therefore, HIV prevention messages that focus on condom use targeting men may effectively reduce a woman’s exposure to HIV/AIDS (Go et al., 2003).

Kocken et al. (2001) assert that despite progress made in the medical surveillance of AIDS, considerable effort still needs to be exercised to address education and behavioral change with regard to safe sex practices. Their study was set in cafes and mosques in the Netherlands. The study involved 589 men, 293 men in the experimental group and 296 in the control group. The men ranged in age from less than twenty to over forty. This qualitative study of Turkish and Moroccan men living in the Netherlands showed that “unsafe sex” practices occurred among sexually active men. In the study men reported that condom use was unpleasant and cited resistance to condom use because of religious teachings that promoted a negative association of condom use with extramarital sex (Everaert & Lamur (1993) and Gelder & Lamur (1993), as cited in Kocken et al., 2001). The researchers further identified “targets” (determinants of behavior) of an effective peer AIDS education program, and used the principles of the Health Belief Model in developing a program. The program purpose was to: 1) increase knowledge of the spread of AIDS; 2) clarify misunderstandings and unreasonable fears of HIV transmission; 3) develop a realistic appraisal of the risk of attracting AIDS, including erasing the prejudice regarding AIDS being a disease of homosexuals and a disease related to nationality or culture and; 4) enhance positive beliefs about self-efficacy and
intentions regarding condom use. The study found and explored barriers of diminished satisfaction with sex using condoms, of buying condoms, along with the benefit of the protective effect of condoms, and perceived self-efficacy of using condoms (Kocken et al., 2001).

Kocken et al. (2001) reported that, “beliefs, and not actual behaviors, were central” in their study. They found that the belief that condom use is beneficial in AIDS prevention was already widespread among Turkish and Moroccan men. From their peer AIDS education program, the researchers found an intention to use condoms among Moroccans and absence of intention among Turks (Kocken et al., 2001). They went on to theorize that this effect may indicate that talking about condoms is less accepted among Turks (Kocken et al., 2001). In addition, they assert an effective AIDS education program must take into consideration group characteristics, such as nationality (values related to culture, religion and ethnicity) when condom-related subjects are pursued. Discussions of sexual contacts outside the traditional roles of marriage within the Muslim community turned out to be difficult in the conservative Muslim culture of Turks and Moroccans despite the clear presence of these practices. This conclusion was reached based upon close examination of activities of the experimental and control group education sessions, which disclosed to them that less attention was paid to the demonstration of condom use during the Turkish sessions than during the Moroccan sessions.

In the Kocken et al. (2001) study, randomization of visitors to the study venues (cafes and mosques) was not possible. Instead, the localities in which the AIDS education took place were randomly
assigned to the experimental and control groups. In view of this, unknown or previously unidentified bias may have impacted the groups by affecting respondent answers to questions or their ability to comprehend subject matter presented to them. The population of the study was limited to Turkish and Moroccan men living away or visiting from their home countries. Additionally, the question arises as to the influences of the Netherlands foreign values and culture on the respondent’s answers to intimate questions.

Nas, Tanner and Yildiz (1999) identified the seroprevalence of syphilis, HIV-1 infections and HBV carriers among pregnant women who applied for antenatal care, that there is no substantial data related to the prevalence (incidence) of syphilis and HIV-1 infections during that study’s “recent years” in Turkey. Three thousand and fifty pregnant women (all except 7 were married) were screened for syphilis, hepatitis B surface antigen (HbsAG), and human immunodeficiency virus-one (HIV-1) antibody at their initial antenatal visit. The investigators conclude that the absence of syphilis and HIV-1 infection in the women studied could only be explained by Turkish low-risk traditional life, which strictly restricts premarital sex, multiple sex partnership, homosexual activity and substance abuse in both rural and urban areas.

Since syphilis, HIV and HBV infections share sexual contact as a common route of transmission, a correlation for prevalence rates was expected (Ter Meulen et al., 1989, as cited in Nas, Taner & Yildiz, 1999). Nas, Taner & Yildiz did not find a correlation between HBV and the other two infections. They concluded that although the number of
patients they had screened was small (n=3050), their findings suggest that routine antenatal screening for syphilis and HIV-1 infections is not necessary among the low-risk (traditional lifestyle) population in Turkey (Nas, Tanner & Yildiz, 1999).

The researchers (Nas, Tanner & Yildiz, 1999) provided few details regarding the specific screening tests involved in their study. The variability of sensitivity and specificity between screening tests may have directly impacted the numbers of identified infections. Without identifying specific tests involved, there is little upon which to base the degree of confidence to be placed in the author’s findings. Should the author’s assertion that in Turkey risk for both syphilis and HIV-1 infection is low when considering the principles of the Health Belief Model, decreases the perceived susceptibility of Turkish women to those infections and presumably decreases their probability of adopting preventive health behaviors such as condom use.

In Özarmagan and Bingham’s 2001 study of Turkish females with syphilis, the source of infection was their husbands in 50 to 60% of cases. As reported by the authors, married women rarely have extramarital sexual intercourse further implicating their male partner. The first case of HIV infection was identified in Turkey in 1985. By June 2000, a total of 1067 HIV/AIDS cases had been reported. Of these cases, 57% are believed to have been acquired through sexual intercourse. The incidence and prevalence of HIV infection in Turkey is not accurately known, although cases have been reported from almost every region. The majority of cases reported are in the large urban
cities, such as Istanbul, Ankara and Izmir (Özarmagan & Bingham, 2001).

Özarmagan and Bingham (2001), report that Turkish lay persons knowledge regarding STIs is poor. Modern diagnostic techniques are not widely employed and there is little standardization of medical treatments. Surveillance arrangements (reporting and application of health related laws) are limited, and results are frequently ignored, with the result that the true incidence of STI in Turkey is unknown. However, based upon the known syphilis epidemic in neighboring Russia, other border states, and the cross border travels of the Turkish and neighboring populations over that border, the researchers believe the incidence of syphilis is definitely increasing in Turkey, and probably that of other infections, too.

Özarmagan and Bingham (2001) report “there has been a high level of governmental involvement in HIV prevention in recent years and it is now believed that most HIV transmission in Turkey is by the heterosexual route”. Though prostitution is officially condemned in Turkey, the government itself oversees brothels under its’ control. The women in these brothels are checked for STI/HIV in health centers while employed by the sex industry. However, the Turkish government’s direct involvement in the sex trade creates an appearance of a conflict of interest, which may adversely impact efforts to report on and control the spread of STI and HIV in Turkey.

Turkish businessmen frequently travel to Russia, North Africa and some Asian republics. During this travel, sexual mores are diminished, set aside, or forgotten, presumably resulting in Turkish
men engaging in sexual contact with women (and men). This results in an increased incidence of HIV infection and other STI in Turkish men who travel outside of Turkey (Özarmagan and Bingham 2001). Condom usage "during casual sexual contact" is infrequent, with registered prostitutes more likely to insist on the use of a condom. More significantly, women working illegally as prostitutes in these areas often do not use barriers, such as condoms and feel obliged to acquiesce to their customer's wishes not to use prophylaxis (Özarmagan and Bingham 2001).

Özarmagan and Bingham's (2001) findings are consistent with geographic trends worldwide and provide a basis for motivating preventive health behaviors, such as condom use through application of the HBM in Turkish women. However, Özarmagan and Bingham's findings clearly lay in stark contrast to those asserted previously by Nas, Tanner and Yildiz (1999) whose findings, if true, would decrease Turkish women's perceived susceptibility to STI/HIV/AIDS infections and thereby presumably decrease their probability of adopting preventive health behaviors such as condom use. Specifically, Özarmagan & Bingham highlight the perceived susceptibility to contracting infection, the seriousness of infection, the benefits from avoiding exposure, and the barriers created by Turkish men who resist the use of condoms during intercourse and who can be violent in a culture that fails to protect women from domestic violence. Keeping the HBM principles in mind, the researchers provide a consistent basis for crafting educational programs, which can highlight these points in
hopes of shaping positive preventive health behaviors such as condom use in Turkish women and men.

According to Ungan and Yaman (2002), the first AIDS case in Turkey was diagnosed in 1985. Initially two cases were identified and cases increased annually with thirty-four new cases reported in 1990. Ninety-one new cases were reported in 1995, and 119 new cases were reported in 1999. According to statistics of the Turkish Ministry of Health in December, 1999, the total number of HIV positive patients was 983 (Turkish Health Ministry, 2000, as cited in Ungan & Yaman, 2003). These numbers are the official numbers of the Turkish Ministry of Health. However, it is asserted by these researchers that it is known that infectious disease increases geometrically as the number of infected patients increase. Based on the two cases in 1985, the actual number of the patients in 1999 was calculated to be at about 17,000. Ungan and Yaman (2002) conclude that, according to the information of the Turkish Ministry of Health, AIDS is considered to be in its beginning phase, but based on the calculations above; the researchers assert that AIDS seems to have become a health problem for Turkey already.

In a report of AIDS knowledge and educational needs of technical university students in Turkey, Ungan and Yaman (2002) examined the need for new courses on AIDS and sexual health education in technical university curricula. Their cross-sectional exploratory study examined Turkish university student’s knowledge, sexual-risk behaviors, attitudes toward AIDS and educational needs concerning AIDS. Each of these factors would influence the probability of
adopting preventive health behaviors according to the HBM. One thousand four hundred and twenty-seven new registrants at a university participated in and answered a 32-item, self-administered questionnaire. The response rate was 84%. Of those, 30% reported condom use during their most recent sexual encounter.

Ungan and Yaman (2002) conclude from their investigation that the sexual education of adolescents within the Turkish family is poor. The findings showed that it is only possible to talk about sexuality among friends/intimates in a covert way. Supporting this finding, sexual information for young people in Turkey concerning sexual relationships and marriage is still limited (Aral & Fransen, 1995).

Ungan and Yaman's (2002) study focused on the responses of only new registrants from the Middle East Technical University. Study of only students represents a narrow focus within the Turkish population.

Public Literature

Yaser in two non-research articles reports on an extensive advertising campaign designed to implement a Contraceptive Social Marketing (CSM) program sponsored by the Turkish Family Health and Planning Foundation in September, 1988. The source of demographic and statistical data reported by the author was not clearly identified in the articles. Reportedly the program was designed to increase the availability and use of quality, low-cost contraceptives in Turkey, namely condoms and low-dose pills. The program was projected to add approximately 2.2 million new users of these modern contraceptive methods over a five-year period. Condom use was promoted as a reliable and affordable product suitable for family planning. As part
of the promotional strategy, a new condom brand, "OK" was developed, and CSM received approval from Turkish Radio and Television (TRT) to air "OK" condom advertising publicly. This was the first time that TRT permitted the airing of brand specific condom advertising in the history of Turkish television.

Yaser asserts that there are four critical factors influencing the contraceptive marketing environment in Turkey: 1) Awareness of contraceptive methods is high, 2) Current prevalence levels for those using modern methods include 31% among married women. Traditional method users (withdrawal, rhythm method and others) account for 32.3% and those who do not use any method make up 36.6%, 3) The Turkish commercial contraceptive market is well developed. Of that market, high dose oral contraceptives dominate, 4) In Turkey, a law concerning the promotion of ethical products effectively prohibits the use of television and radio to advertise oral contraceptives, since the pill is regarded as an ethical product (Yaser, 1992; Yaser, 1993).

Within the framework of the Health Belief Model, educational programs which promote the use of condoms by Turkish women and men, may be more successful in overcoming the barrier to condom use when its' suggested use is seen by Turkish men in terms which can be perceived as having an acceptable purpose such as family planning and not exclusively promoted as a preventive health behavior for the prevention of STIs. In Yaser's reviews the national education program regarding increased acceptance of men's use of "OK" condoms, was facilitated by Turkish law, which prohibits the use of television and radio to advertise oral contraceptives. As a result, a potential
barrier faced by Turkish women in efforts to negotiate condom use, men’s lack of acceptance of the product, was reduced. Reducing men’s resistance to condom use would enhance Turkish women’s inclination to exercise preventive health behaviors such as condom use during sexual intimacy with their partner.

The realities of social change in Turkish culture some twenty years after Yaser’s articles include subsequent election of a more conservative national government in the mid 1990’s. This fact should be considered when assessing the relevance of his findings and approach to a successful condom marketing program today, in a nation different than the one described by him in 1992 and 1993.

Summary

In consideration of the principles found within the Health Belief Model, educational programs that suggest the use of condoms by Turkish women may be successfully advocated when the use of the condom has either the perceived benefit of birth control and or as a preventive health behavior taken by the woman, preventing the spread of HIV/STI. Since the concept of birth control may appeal to Turkish men in regards to their concerns regarding increased economic demands of larger families, the suggestion of condom use under these terms may be more acceptable in a society which is very hierarchical and where men are expected to dominate women. The secondary benefit then arises where the woman is able to practice the preventive health behavior of condom use within their partner’s acceptable psychological framework without fear of violence or other severe consequences for having suggested condom use.
This review of literature explored developing programs using the Health Belief Model as a construct to overcome barriers to condom use as a STI/HIV resistant preventive health behavior by Turkish women. The available literature on the subject of condom use in Turkey was found to be limited. The HBM provides a theoretical framework, which facilitates the development of strategies for training Turkish women in safer sex negotiation and thereby facilitates condom use as a preventive health behavior. The resultant interventions used by health care providers including Nurse Practitioners must be tailored to address the reality of unequal relationship power dynamics in this population. In this manner Turkish women can become empowered to successfully negotiate condom use, while decreasing the risk of violence they face upon the mere suggestion of condom use. By using cultural and gender sensitive strategies in teaching their patients how to overcome barriers to condom use, Nurse Practitioners can help decrease the spread of HIV/AIDS and sexually transmitted infections in the female Turkish population.
References


