

Perceptions of Determinants of Condom Use Behaviors Among Male Clients of Female Sex Workers in Indonesia: A Qualitative Inquiry

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Abstract

This study aimed to explore perceived determinants of condom use behaviors among male clients of female commercial sex workers (FCSWs) in Belu and Malaka districts, Indonesia. One-on-one in-depth interviews guided by the Health Belief Model (HBM) were used to collect the data from participants ($n = 42$). The Framework analysis for qualitative data was employed to analyze the data. Results demonstrated several factors associated with lack of and inconsistent condom use among the participants. They included self-perceived risk of contracting HIV infection, knowledge of the severity of HIV illness and its impacts, and condom use: its benefits and its influencing factors. Additionally, factors including reduced sexual pleasure and the lack of knowledge of how and where to access condoms were important perceived barriers to condom use among participants. Having seen images of HIV-/AIDS-positive people, knowing friends and relatives suffering from HIV, and knowing FCSWs as a high-risk group for HIV infection were the cues to using condoms among several participants. Likewise, self-efficacy was also associated with condom use behaviors among the participants. The findings indicate the needs for HIV/AIDS interventions that include dissemination of HIV/AIDS knowledge, condom promotion, and improvement in the availability of condoms for both FCSWs and their clients.

Keywords

male clients of FCSWs, determinants, condom use behaviors, HBM, Indonesia

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Introduction

The spread of HIV in Indonesia is reported to increase over time. The 2017 AIDS report indicates that HIV cases in the country increased from 859 in 2005 to 55,848 in 2010 and 232,323 in 2016 (Kementerian Kesehatan RI, 2017). The same report reveals that men compared to women in the country were more susceptible to HIV infection (Kementerian Kesehatan RI, 2017). For example, the percentage of HIV infection among men in the past few years was reported having increased from 55.9% in 2011 to 56.7% in 2012, 57.7% in 2013, 58.8% in 2014, 59.4% in 2015, and 63.3% in 2016 (Kementerian Kesehatan RI, 2017). Likewise, the percentage of AIDS cases among men during the same period increased from 49.1% in 2011 to 52.1% in 2012, slightly decreased to 51.7% in 2013, and again went up to 60.4% in 2014, 62.6% in 2015, and 67.9% in 2016 (Kementerian Kesehatan RI, 2017).

Male clients of female commercial sex workers (FCSWs) are one of the groups at risk for the acquisition

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of HIV and other sexually transmitted infections (STIs) due to frequent unprotected sexual encounters with FCSWs (Fajans, Wirawan, & Ford, 1994; Ford, Wirawan, & Muliawan, 2002; Kementrian Kesehatan RI, 2017). Condomless sex has been the most effective route of HIV transmission especially among sexually active age groups in Indonesia (Fauk & Mwanri, 2015; Kementrian Kesehatan RI, 2017). For instance, of the total 155,444 HIV cases diagnosed in the past 5 years, 59% (91,719 cases) were transmitted through condomless sexual encounters, 5.6% (8,670 cases) were spread through injecting drug use, and the rest were unknown (Kementrian Kesehatan RI, 2017). During the same period the infection in the country was more prevalent among the sexually active age group, with 71.7% among people aged 25 to 49 years and 14.9% among those aged 20 to 24 years (Kementrian Kesehatan RI, 2017).

A preponderance of previous studies (Couture et al., 2008; Couture, Soto, Akom, & Zunzunegui, 2010; Jin et al., 2010; Miller, Mendoza, Krone, & Meza, 2004; Nguyen, Nguyen, Trinh, Mills, & Detels, 2009; Ramanathan et al., 2014; Shaw et al., 2013; Suryawanshi et al., 2013; Thorpe, Ford, Fajans, & Wirawan, 1997; Volkmann et al., 2014; Xu et al., 2008) in different settings have consistently reported lack of or inconsistent condom use among male clients of FCSWs, which supports the transmission of HIV as well as other STIs among them. Unpleasantness and/or a reduction in sexual pleasure when using condoms are the most common reasons supportive of their engagement in unprotected sexual encounters with FCSWs (Fajans, Ford, & Wirwan, 1995; Fajans et al., 1994; Ford et al., 2002; Voeten, Egesah, Ondiege, Varkevisser, & Habbema, 2002). Other factors associated with their condomless sex include a lack of perceived risk of contracting HIV, unavailability of condoms immediately before the sexual act encounter, and taking prophylactic antibiotics prior to sexual contacts. Presentability of FCSWs has also been stated to be influential in condom nonuse behaviors among clients due to perceptions that women who are pretty and clean are also healthy (Fajans et al., 1995; Fajans et al., 1994; Ford et al., 2002; Voeten et al., 2002). Trusting a steady FCSW partner, drunkenness, FCSWs' dislike of condoms, condom bursting, and the beliefs that condoms do not protect against HIV infection have been reported as factors leading to inconsistent condom use in clients of FCSWs (Voeten et al., 2002).

Despite the upward trend of HIV transmission through unprotected sexual behaviors among men in the Indonesian context, evidence of factors associated with their condom use behaviors is scarce. This study aimed to explore perceived determinants of condom use behaviors among male clients of FCSWs. The Health Belief Model (HBM) was employed as the theoretical framework guiding the analysis and interpretation of the data.

Methods

Theoretical Framework

The HBM was originally conceived to provide explanations for health (preventative) behaviors (Mikhail, 1981), postulating that the possibility of individuals to adopt or undertake a health-oriented action is subject to their beliefs relating to the following key dimensions: (a) perceived susceptibility—referring to an individual's beliefs of the likelihood of experiencing a condition or disease that would negatively affect his or her health, (b) perceived severity—referring to the beliefs an individual holds about the seriousness of a given disease or condition and its sequelae, (c) perceived benefits—referring to a person's beliefs or opinions about the values or usefulness of taking an action toward the prevention of a disease or toward dealing with an illness, (d) perceived barriers—referring to an individual's evaluation of all negative aspects that could impede him or her undertaking a recommended action or behavior. Perceived barriers may come from a cost-benefit analysis of undertaking an action, (e) cues to action—which plays a role in moving or motivating people to take an action or change their behavior, and (f) self-efficacy—one's beliefs about his or her ability to successfully undertake the behavior required to produce expected outcomes is also a factor that supports one to perform a recommended action or health behavior change (Champion & Skinner, 2008; Janz & Becker, 1984). The perception of seriousness is often based on the evaluation of both medical and clinical consequences of a given disease or condition, or it comes from the beliefs individuals hold about the effects a disease would have on their life. The combination of perceived susceptibility and perceived severity is often labeled as a perceived threat (Champion & Skinner, 2008; Janz & Becker, 1984). Individuals' strength of perceptions of threat has a high influence on individuals' engagement in positive behavioral changes.

Study Design and Procedure

This qualitative study was conducted from January to April 2017 in Belu and Malaka districts, East Nusa Tenggara, Indonesia. Data were collected using one-on-one in-depth interviews with male clients of FCSWs. The inclusion criteria were individuals who were men 18 years old and above and who have had sex with FCSWs. The participants were recruited using a snowball sampling technique. Four initial participants were recruited with the help of a staff member of a nongovernmental organization (NGO) providing HIV/AIDS services in the districts and who knew that they were clients of FCSWs. They were asked to circulate the information sheet containing the researchers' contact details and information about this study among their colleagues who would be willing to participate in the study. Initially, 18

participants contacted the researchers in the following 3 weeks and took part in the study. These participants did send information to their networks and a further 20 participants agreed to be interviewed for the study. We interviewed a total of 42 participants and collected enough data to explain condom use behavioral patterns among the clients of FCSWs (Corbin & Strauss, 1990).

Each interview took place at a time and private place recommended by each participant. All the participants were informed about the purpose of the study through the initial information sheet and on the interview day. Participants were informed that the study had been approved by the Medicine Research Ethics Committee, Duta Wacana Christian University, Indonesia (ref: 386/C.16/FK/2017). They were also informed that the information they were providing would be confidential and each of them would be assigned a unique Study Identification Number to prevent the possibility to link back the data or information to an individual in the future. Before the interviews, each participant was advised that the interview would be recorded and would take approximately take 45 to 90 min and that his participation was voluntary and he may decide to quit without any consequences if he feels uncomfortable about the topics being asked during the interview. To demonstrate that each interviewee had willingly agreed to participate, he signed and returned a written informed consent prior to commencing the interview. Each participant was provided with IDR 100 (=USD 8) to reimburse for their time and transport. It was not an incentive. Light snacks were also provided after the interview.

Data Analysis

The recorded interviews were transcribed verbatim and translated into English by the first two authors (NKF and CYK). Both authors are fluent in both Bahasa and English. Data cross-check between the two authors took place during the transcription and translation period. Data analysis was guided by five steps of qualitative data analysis introduced in the Framework analysis by Ritchie and Spencer (Ritchie & Spencer, 1994). They include

- (a) *familiarization* with the data or transcripts by reading them line by line repeatedly, breaking down into several chunks of data, and giving comments or labels;
- (b) *identifying a thematic framework* by writing down recurrent key issues, concepts, and themes;
- (c) *indexing* to the entire data by making a list of codes (open coding) to look for similar codes and redundant codes to reduce a long list of codes to a smaller and manageable number. This was followed by creating closed coding where codes referring to the same theme were grouped together under one theme. Initially, each coder quickly read the transcripts and

independently made a list of codes based on the data. The codes were then exchanged between the coders and discussed to have the same understanding of the definition of each code. The codes were applied to the data by each coder and then exchanged between the coders, to see differences, and discussed to establish mutual agreement;

- (d) *charting* the data through arrangement of appropriate thematic references in a summary chart so that it could be compared across the interviews and within each interview; and
- (e) *mapping and interpretation* to the data to examine the ideas that made up the main themes in order to see the relationship and association between them (Berkman, Glass, Brissette, & Seeman, 2000; Fauk, Mwakinyali, Putra, & Mwanri, 2017; Ritchie & Spencer, 1994). This framework provides a systematic approach to the management of qualitative data in a coherent and structured way, and enhances rigor, transparency, and validity of the analytic process (Ritchie & Spencer, 1994). Both an inductive approach, with categories emerging purely from the data, and a deductive approach, with categories derived from prior knowledge, were used to analyze the data (Moretti et al., 2011).

Results

Profile of Participants

The general characteristics of the participants are presented in Table 1, which demonstrates inconsistent (38%) and no condom use at all (43%) among the participants. Of the respondents, 81% were younger than 31 years and 93% were single. The majority of them worked as motorcycle taxi drivers (Ojek; 36%) and construction workers (33%).

HIV Self-Perceived Risk

High self-perceived risk or an individual's strong belief of the possibility of contracting HIV infection seemed to be a factor supportive of condom use sex among the participants. A few participants ($n = 8$), for example, commented that being aware of the risk of acquiring HIV infection from FCSWs encouraged them to engage in condom use sexual behavior:

"I am aware that I am at risk of getting HIV if I do not use condoms, so I consistently use condoms" (R1).

"I know they [FCSWs] can transmit HIV to me, so I always protect myself with condoms" (R19).

"I often use condoms when having sex with them [FCSWs] because I am aware that they might have STIs including HIV and I can also be infected if I am not careful enough" (R22).

Table 1. Sociodemographic Profile of Study Participants.

Characteristics	No. of respondents N = 42 (%)
Age	
19–25	16 (38)
26–30	18 (43)
31–35	8 (19)
Marital status	
Single	39 (93)
Married	3 (7)
Number of sexual encounters with FCSWs in the past 6 months	
1–5 times	5 (12)
6–10 times	11 (26)
≥11 times	26 (62)
Number of FCSWs they had sex with in past 6 months	
2–5	13 (31)
6–10	22 (52)
≥11	7 (17)
Condom use with FCSWs in past 6 months	
Never	18 (43)
Sometimes	16 (38)
Always	8 (19)
Occupation	
Ojek (motorcycle taxi drivers)	15 (36)
Construction workers	14 (33)
Harbor workers	10 (24)
Unemployed	3 (7)

Note. FCSWs, female commercial sex workers.

In contrast, a low self-perceived risk of acquiring the HIV infection or any other STIs was found to negatively influence participants' sexual behaviors. This led to the majority of participants using condom inconsistently ($n = 16$) or not using condoms at all ($n = 18$), hence enhancing the susceptibility to HIV and other STI acquisition:

“I am sure that I will not get HIV or syphilis through having condomless sex with *ayam* because I am healthy [*ayam* is the term used for FCSWs, literally means chicken]” (R7).

“I don't think that I am in danger just because of sleeping with them [FCSWs] without using condoms because the ladies I slept with looked fine, were not sick” (R11).

“I visited them [had sex with FCSWs] just a few times, you can count with your fingers [not more than 10 times] so I think I would not get infections from them even though I did not use condoms” (R21).

Low self-perceived risk of acquiring HIV infection among the majority of the participants was mainly due to the lack of information and knowledge about how HIV and other STIs are transmitted and can be prevented. This low HIV self-perceived seemed to influence participants' engagement in inconsistent condom use or

condomless sexual practices favoring HIV transmission among them:

“I just recently started to learn about HIV/AIDS, and now I know a little bit about the means of HIV transmission but before that I did not know, so I did not use condoms at all and I did not think of any risk” (R3).

“I do not know anything about HIV transmission and prevention.... I once got a condom; she [FCSW] gave it to me before we had sex. She said that was for safety reason but I did not understand what she meant by safety so I threw it to the bin” (R33).

“If I know that HIV can be prevented by using condoms I would have started using it since long time ago” (R28).

Knowledge of the Severity of HIV Illness and Its Impacts

Knowing the seriousness of HIV/AIDS and its impact on health and life were found to shape the sexual behaviors of the participants. For example, for a few participants ($n = 8$), the negative impact or the peril the disease would cause on their health and life led them to using condom consistently when engaging in sexual activity with their FCSW partners:

“To be honest I feel scared of HIV/AIDS because there is no cure for it, once you get it you will live with it for the whole life. This reminds me to always use condoms every time I have sex with the sex workers” (R9).

“I know HIV is very dangerous, it will stay forever in your body and ruin your life once you get it. That is why I always use condoms” (R14).

“I use condoms when having sex with sex workers because I do not want to get infected with HIV. I once read that HIV positive people are always dependent on medicine, I do not like to take medicine everyday” (R30).

However, the majority of the participants ($n = 28$) who were less exposed to or lacked information about the impact of HIV/AIDS seemed to have low level of perception of the severity of HIV infection and inconsistently used condoms or consistently engaged in sexual behavior with nonuse of condoms:

“I know nothing about HIV/AIDS and its consequences. Honestly, I am not afraid of it because I do not know what it is and what it can do to my body.... I do not use condoms at all” (R5).

“I never thought of it [HIV/AIDS] and did not know that it has detrimental effects.... About condom use, I rarely use [condoms] because I often do not have condoms when having sex” (R12).

"I do not know much about HIV/AIDS so even though I do not use condoms once having sex with them [FCSWs] I am not afraid of getting it" (R35).

Condom Use: Its Benefits and Influencing Factors

Condom use was believed to prevent the spread of HIV infection as well as other STIs; hence, it was associated with the sexual behavior of the participants. Such a belief was reflected in the responses of a few participants ($n = 8$) who reported having consistently used condoms due to the awareness of the protective functions of condoms as the means of HIV and STI prevention:

"I always use condoms because I know using condoms can prevent the transmission of HIV and syphilis" (R1).

"Condoms function to protect me from getting any STIs including HIV, therefore I always put on when having sex" (R37).

"I consistently use condoms because I do not want to have it [HIV]" (R14).

However, participants' belief and knowledge about the efficacy of condoms preventing the transmission of STIs including HIV did not always lead to consistent condom use sexual behaviors. Inconsistent use of condoms was reported among participants ($n = 6$) who were aware of the protective functions of condoms as illustrated in the participants' comments in the following text:

"I know about the functions of condoms including to prevent pregnancy and HIV transmission but sometimes I just simply forget to use [condoms]" (R25).

"I use condoms but not always even though I know it is important to protect me from contracting infections. That is because I often hang around with my friends in the evening without any plan to have sex [with FCSWs] so I do not bring condoms with me but sometimes we end up in brothels" (R36).

Furthermore, it was evident that lack of perceived benefits of condom use led to participants' consistent engagement in condomless sex ($n = 28$). This was also compounded by the fact that some participants were unaware of the existence of condoms. This was not a surprising finding because the majority of the participants who did not use condoms at all seemed to lack the knowledge of what condoms were and of condoms' protective functions against HIV transmission. These assertions are supported by the following excerpts from participants:

"I am not aware at all that there is such thing [condom] that can prevent HIV transmission" (R2).

"How can I know about its benefits if I do not about what it is" (R6).

"I once heard some friends of mine mentioned the name [condom] but I have not seen it yet and do not know how it works" (R34).

Barriers to Using Condoms Among the Clients of FCSWs

The displeasure and poor sexual experiences of using condoms during sexual intercourse were indicated to play a role in influencing sexual behaviors of the participants. For example, feeling uncomfortable during sexual intercourse, less sexual satisfaction, and reduced sexual pleasure or sensation were expressed as the negative aspects that impeded the consistent use of condoms among several participants ($n = 15$):

"I used condoms a few times and it did not feel the same as without condoms. I felt uncomfortable so I do not use condoms that often" (R4).

"I feel unsatisfied every time I use condoms so sometimes I use [condoms] sometimes I do not" (R16).

"The feeling and experience are different; I mean the sexual pleasure and sensation are better without condoms. Therefore, sometimes I just want to feel the sensation without condoms" (R27).

The price of condoms was also depicted by a few participants ($n = 14$) as an additional factor associated with participants' condom use behaviors. The high price of condoms and the lack of cash at the moment of need prevented them from purchasing condoms prior to their engagement in sexual activity with FCSWs. These led to inconsistent and condomless sexual behaviors that enhance their susceptibility to HIV infections:

"I am aware to bring condoms every time I want to visit them [FCSWs] but sometimes I could not buy. They are expensive" (R8).

"I do not consistently use condoms because I do not always have enough cash to buy, the prices are also quite high" (R31).

"I never used condoms but I once intended to buy [condoms] at pharmacy even though I did not buy at last.... I thought the prices are two or three thousand rupiahs [Indonesian rupiahs] but in fact they are more than ten thousand [rupiahs]" (R15).

Furthermore, factors including lack of information about where to access or buy condoms and how to use them correctly, and feeling shameful or uncomfortable to access condoms were also the barriers to condom use sexual behavior among the participants:

“I heard about condoms but I do not know where to get them” (R20).

“I never buy and never use condoms because I am not comfortable to buy and do not know how to put on condoms” (R32).

“She [his sexual partner, FCSW] told me about condoms and asked me to buy and use next time but I feel uncomfortable to buy. It will be shameful if people stare at me when I am buying it.... I never buy and never use [condoms] either” (R17).

Participants' Trigger/Cue and Ability to Use Condoms

Some participants reported having received some education or information sessions about HIV infection. For these participants, images of people, friends, or relatives who had HIV/AIDS and sexual health conditions had an influence on their condom use behaviors. A few participants ($n = 12$) commented that seeing images of reproductive organs of HIV/AIDS and other STI patients displayed on PowerPoint during HIV/AIDS information sessions was the cue that triggered the action to use condoms. Likewise, knowing friends and relatives or other people who suffered from STIs or died from AIDS motivated a few of them ($n = 14$) to change their sexual behaviors and use condoms when copulating with FCSWs:

“I started using condoms after seeing what happened to the bodies of HIV/AIDS infected people in the pictures during HIV/AIDS information session held by the [local] AIDS commission.... I do not want to suffer the same way” (R14).

“Two friends of mine and also one of my relatives who got infected with syphilis and gonorrhea, told me that they felt very painful. Besides, their reproductive organs looked scary. That motivates me to start using condoms” (R24).

“I know a guy who died a few months ago, he used to visit the women [FCSWs]. People said that he got AIDS. It makes me scared and since then I do not do it [have sex with FCSWs] that often, and I always make sure to bring condoms with me” (R42).

Having information or knowledge of FCSWs as a high-risk group for HIV infection and other STIs was another cue for sexual behavioral change among the participants. The level

of knowledge about these infections raised men clients' awareness to use condoms and to protect themselves from HIV and other STI infections when accessing the service of FCSWs. Two participants commented as follows:

“I started using condoms even though inconsistently since I heard the explanation of the local AIDS Commission staff that they [FCSWs] are one of the high-risk groups for HIV infection. I am afraid that some of them here might have been infected with HIV, who knows” (R38).

“I regularly used condoms because I know they [FCSWs] sleep with everybody who visits them. If they have STIs or HIV then they can possibly transmit it to me if I do not protect myself” (R40).

Although the knowledge of how HIV infection was transmitted triggers the action, this was not always the case. Some participants who knew how to protect themselves and prevent HIV and other STI acquisition were unable to take action and protect themselves from infection due to unavailability of condoms at closest proximity when they were about to engage in sex with their service providers (FCSWs). The following quotes illustrate such assertions:

“A friend of mine got syphilis last month. He showed me what happened to his reproductive organ, I was scared. That motivates me to start using condoms but I do not know yet where to get them” (R13).

“I once attended HIV/AIDS workshop where I got explanation about HIV/AIDS and could see how the infected bodies look like. These make me committed to using condoms but sometimes I do not use because I just do not have [condoms] at the time of having sex” (R23).

Self-efficacy or individual beliefs in one's own ability to use condom correctly was also an influential factor associated with the sexual behavior of the study participants. On the one hand, being able to use condoms correctly was stated by several participants ($n = 8$) as a factor supportive of consistent condom use behaviors among them. On the other hand, the majority of the participants who inconsistently used condoms or never used condoms at all commented that not knowing how to put on condoms correctly was one of the reasons they did not use condoms or used condoms inconsistently:

“I know how to use condoms correctly and always use [condoms] once having sex with the sex workers” (R9).

“I once got an explanation from a friend of mine and he showed me how to put on a condom. So I can use condoms correctly. If I have condoms I always use when having sex” (R18).

"I do not know exactly how to use condoms in a correct way. I just put on but I was not sure whether it was correct or not. This might be the reason why I did not feel comfortable when using condoms.... I use condoms but not always" (R29).

"I do not know yet how to use condoms and as I have told you I never used condoms before. My colleagues once told me about it [condom] and I want to use but I am not sure yet. I think I need to learn how to use it correctly" (R26).

Discussion

High prevalence of HIV infection and other STIs among the clients of FCSWs as well as FCSWs themselves has been reported in several studies in different settings (Couture et al., 2008; Jin et al., 2010; McLaughlin et al., 2013; Nguyen et al., 2009; Papworth et al., 2013; Shaw et al., 2013; Shaw et al., 2011; Xu et al., 2008) across the globe. Inconsistent condom use or condomless sex with multiple FCSWs has been indicated in many studies as one of the main contributors for the transmission of HIV and other STIs among clients (Couture et al., 2008; Couture et al., 2010; Faulk, Mwakinyali et al., 2017; Jin et al., 2010; Miller et al., 2004; Nguyen et al., 2009; Ramanathan et al., 2014; Shaw et al., 2013; Suryawanshi et al., 2013; Volkmann et al., 2014). This was confirmed by the findings of the current study, with the majority of participants reporting not using condoms at all or inconsistently using condoms during sexual encounters with their FCSW partners. Consistent with the previous findings (Basen-Engquist, 1992; Fajans et al., 1994; Faulk, Crutzen et al., 2017; Hounton, Carabin, & Henderson, 2005; Mahoney, Thombs, & Ford, 1995; Voeten et al., 2002), the findings of this study indicate an obvious relationship between low self-perceived risk of acquiring HIV infection, low perceived severity of HIV/AIDS, and condom use behaviors among the majority of the participants. The lack of knowledge of how HIV is transmitted, how it can be prevented, and HIV/AIDS consequences was the factor supportive of low HIV self-perceived risk and low perceived severity of HIV/AIDS among the clients of FCSWs, which led to sex with inconsistent and nonuse of condoms.

The findings of the current study also indicate that some participants perceived using condoms as beneficial, which was one among the factors supportive of condom use behaviors among participants. However, the study further suggests that such perceived benefits of condom use did not always lead to condom use behaviors, because even though they were aware of the benefits, some participants still used condoms inconsistently, or did not use condoms at all. Some of the reasons were that they simply forgot to bring condoms while visiting FCSWs and that they engaged in sex with FCSWs without any prior plan, hence not bringing condoms. These findings are in

conformity with findings from previous studies (Faulk & Mwanri, 2014; Malebranche, Fields, Bryant, & Harper, 2009; Wheeler, 2006; Williams, Wyatt, Resell, Peterson, & Asuan-O'Brien, 2004; Wulfert, Wan, & Backus, 1996) reporting that most of their participants were convinced about the benefits of using condoms but these perceived benefits did not translate to condom use behaviors among them. Lack of information or knowledge of the existence of condoms and the lack of knowledge of protective functions of condoms depicted in this study seemed to be among the main reasons for low perceived benefits of condom use behavior among the majority of the study participants, leading to condomless sexual practices that made them vulnerable to HIV transmission. Supporting the findings of previous studies (Faulk, Crutzen et al., 2017; Faulk & Mwanri, 2015; Lin, Simoni, & Zemon, 2005; Steers & others, 1996; Zak-Place & Stern, 2004), the results of this study report positive relationship between self-efficacy or the belief about one's ability to use condoms correctly and condom use behavior among several participants. Meanwhile, the majority of study participants who did not know to use condoms correctly reported having used condoms inconsistently or not using condoms at all. Besides, the study findings also suggest an association between cues such as seeing the images of HIV/AIDS-infected people and knowing friends and relatives suffering from STIs and condom use behavior among the clients of FCSWs. This was because such cues increased self-perceived risk and fear of acquiring and suffering from HIV and other STIs.

In line with the previous findings reported elsewhere (Fajans et al., 1994; Faulk, Mery, Sigilipoe, Putra, & Mwanri, 2017; Ford et al., 2002; Hounton et al., 2005; Voeten et al., 2002; Volk & Koopman, 2001; Wulfert et al., 1996), the current study depicts a positive relationship between barriers, including feeling uncomfortable while using condoms, decreased sexual pleasure, low satisfaction and sexual sensation, unavailability of condoms immediately before the use, and inconsistent or lack of condom use among participants. Factors such as high prices of condoms, not knowing the places to access or buy condoms, feeling ashamed or uncomfortable to access or buy condoms, as well as unawareness of the existence of condoms and their protective functions were also barriers to condom use or safe sex behaviors reported among the clients of FCSWs. Meanwhile, other barriers to condom use as previously reported (Fajans et al., 1995; Fajans et al., 1994; Faulk & Mwanri, 2015; Ford et al., 2002; Voeten et al., 2002), including taking prophylactic antibiotics, good appearance of FCSWs such as pretty, young, clean, and healthy and trusting a steady FCSW, drunkenness, FCSWs not liking condoms, condoms burst, and belief that condoms do not protect against HIV infection, were not identified in the current study.

Limitations and Strengths of the Study

There are several limitations that need to be considered in interpreting the results of this study. First, it has to be noted that the findings of this study mainly reflect the situation of the participants in Belu and Malaka districts, which used to be one district called Belu prior to 2012. Second, the fact that we recruited the study participants from these two similar settings might have resulted in undersampling the clients of FCSWs from different sites with different characteristics. This might have resulted in an incomplete overview of the factors associated with condom use behaviors among the clients of FCSWs. Third, the use of HBM could also be a limitation as it led to the identification of individual-level explanatory factors and did not address the diverse cultural, structural, political, economic, relational, and contextual factors that influence behaviors that put men at risk for HIV. Fourth, the distortion of response that occurred during the interview with some participants due to the presentation of questions related to socially undesirable behaviors is also a limitation of this study.

Despite these limitations, these findings could still be widely used to inform HIV-/AIDS-related strategies and interventions for the clients of FCSWs in Indonesia and all parts of the world with similar participants. Besides, to the best of our knowledge, this current study represents the first qualitative investigation of factors associated with condom use behaviors among the clients of FCSWs in the Indonesian context. A qualitative approach was used in this study because it provides in-depth and highly contextualized information and insights into pertinent issues associated with HIV risk sexual behaviors among the clients of FCSWs in Belu and Malaka districts. Further studies with a larger number of heterogeneous participants from different sites and covering the diverse cultural, structural, political, economic, relational, and contextual factors that influence behaviors that put men at risk for HIV are recommended, since the results of such studies can be generalized to larger communities in Indonesia and other similar settings.

Conclusions

The current study reports that perceived susceptibility to HIV infection, perceived severity of HIV/AIDS disease, perceived benefits of condom use behaviors, availability of cues to condom use and self-efficacy toward performing condom use correctly are the factors supportive of condom use behaviors among several clients of FCSWs. Meanwhile, low perceived threat of the possibility to contract HIV infection and the seriousness of HIV/AIDS, lack of perceived benefits of condom use behaviors, low self-efficacy to use condom correctly,

and high perceived barriers including feeling uncomfortable during sexual intercourse, reduced sexual pleasure or satisfaction, high price of condoms, lack of information about where to access condom, and feeling shameful of accessing or buying condoms are the hindrances to condom use behaviors among the majority of the clients of FCSWs. The findings indicate that participants are at high risk of acquiring HIV infection due to their frequent unprotected sexual encounters with FCSWs and could also be agents for rapid spread of the virus to the general population in communities where they live, interact, and move into. The study findings can be used to inform the development of strategies and policies that address a need for HIV/AIDS education and interventions including dissemination of HIV/AIDS knowledge and information, condom promotion, and improvement of the availability of condoms for both FCSWs and their clients.

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