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Determinant of behavioural change for condom use among out of school youths in Tanzania

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ABSTRACT

This exploratory qualitative study aimed to identify perceived benefits, barriers and motivational factors impacting condom use for out-of-school youth ages 15-24 years. The study was carried out in Kinondoni Municipality of Tanzania between April and May 2010. A semi-structured guide was used in 8 in-depth interviews and two focus group discussions (FGDs) among 30 respondents chosen through convenient sampling. The Health belief Model (HBM) served as the conceptual framework for the study. Findings indicate that psychosocial and utilization problems were identified as main barriers to condom use. Additionally, lack of negotiation skills for safer sex was perceived as a serious impediment to condom use, particularly among women. An effective behavior-change programme for HIV prevention, which address psychosocial and utilization related barriers to condom use is needed. A well-designed strategy would improve condom use by putting emphasis on skills for correct condom use and negotiation for safer sex, particularly for women.

Keywords: Condom use, out-of-school youth, Health belief model, Tanzania, HIV/AIDS

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Introduction: A population that presents a current challenge to prevention and control of HIV/AIDS is youths aged 15 to 24 years. Globally, youths aged 15-24 years constitute 18% of the world's population [1], and 31% of Tanzania's population [2].Youth's are vulnerable to risky behaviors [3], particularly risky sexual behaviors which can expose them to sexually transmitted infections, including HIV/AIDS [1;4].

Globally, it is estimated that 5.4 million young people aged 15 to 24 are living with HIV; 3.2 million reside in sub-Saharan Africa (International Youth Foundation, 2010). In fact, in sub-Saharan Africa (SSA) youth lack access to HIV prevention education programmes, with only 8 per cent of out-of school youth having access such programmes [1; 3; 4; 5]. This indicates that out-of-school youth are more at risk of getting HIV infection due to lack of access to HIV prevention programmes.

Although the overall HIV prevalence in Tanzania is around 4.5 %, the high HIV prevalence of 7.9 % among youths aged 15 to 24, indicates that HIV infection is still a major problem among this at risk age group [4; 6; 7].

Several studies have documented the cost-effectiveness of condoms as a relatively simple intervention to prevent HIV infection [4]. However, studies on adolescent sexuality have shown a significant increase in sexual experiences at a younger age concomitant with inconsistent condom use [4; 8, 9;10].

To motivate youths to engage in safer sex, interventionist need insight in the psychosocial, cultural and utilization factors associated with non-condom use [11; 12; 13]. In fact, a major challenge

facing HIV prevention efforts among out-of-school youths aged 15 to 24 in Tanzania, is inadequate research on factors that influence youth's intention to use condoms. Studies that have tried to identify factors associated with non-condom use among youths and adolescents in Tanzania were mainly on knowledge, attitudes and practices (KAP), which did not use behavioral change models such as the Health Belief Model (HBM).

This exploratory qualitative study addresses a theory-based analysis of factors that motivate or hinder condom use among out-of-school youths in an urban setting. The study was based upon a conceptual framework integrating Health Belief Model [14; 15]. According to the HBM, individuals will take health related actions (e.g., condom use) : (1) if they perceive themselves to be vulnerable of contracting a specific illness, and if they perceive this specific illness as severe, (2) if they have a positive attitude towards the health behaviour, that is if they perceive the benefits of performing this certain behaviour to outweigh the barriers or negative consequences, (3) if they believe that they can successfully take a recommended health action, and (4), if they are 'triggered' to act [16].

Materials and Methods:

Study area and Participants: The study was conducted in Kinondoni municipal, Dar es Salaam, Tanzania. Kinondoni municipality is one of three municipal councils with a population of 1.4 million and youths aged 15-24 are estimated at 234,003 (17.2%). The study site was selected based on a comparatively high HIV prevalence (9.3 %) than the national prevalence of 5.9 % [2; 6; 7].

The convenient sample of our study was carried out between April and May 2010 to select 30 participants. All eligible participants aged at least 18 years old and above consented to participate in the study. Sampling was done with assistance of leaders of youth groups found in the study site.

Data collection

We conducted semi-structured in-depth interviews with four males and four females in an urban setting. We conducted a total of eight interviews; each interview lasted between 60-90 minutes, and was recorded, after informed consent from the participants. We also conducted two focus group discussions (FGDs) included 10 males and 12 females' participants. Both the In-depth interviews and FGDs addressed participant's perspectives on perceived vulnerability/severity of HIV/AIDS, beliefs,

benefits and barriers to condom use and motivational factors associated with condom use. Interviews were conducted by the first author [EK] and two trained research assistants in *Kiswahili*-a language known to all participants.

Ethical considerations: The study protocol received ethical clearance from Tanzania's National Institute for Medical Research, and the Kilimanjaro Christian Medical College University Research Ethics Committee.

Data management and analysis: All interviews and FGDs were conducted in Kiswahili (the official language of Tanzania), tape-recorded, transcribed verbatim, and translated into English by the first author [EK]. A framework approach was used for analysis, combining the use of ATLAS.ti and manual techniques. Using the framework approach, the identification of key themes and sub-themes fed into the development of a thematic framework, which was systematically applied to sort data.

Translated transcripts were coded by the first author, and an independent qualitative analyst verified the coded data. Discrepancies in coding were discussed among analysts and resolved. The texts were read repeatedly to identify major themes and each theme was broken down into concepts. Representative, verbatim quotes were selected to illustrate key findings [17; 18].

Results:

Sample demographics: A total of 30 respondents were involved in this study in Kinondoni municipality. Themes that emerged were related to perceived susceptibility and severity of HIV infection, beliefs on condom use, perceived benefits /and barriers to condom use, self efficacy and cues to condom use.

Perceived susceptibility and severity of HIV: Most participants perceived to be highly susceptible to HIV infection. It was common for respondents to mention risky sexual behaviours such as: multiple sexual partners and inconsistent condom use as predisposing factors for HIV infection. One participant has this to say:

"I am at risk of getting the disease [HIV] because. I've a permanent sexual partner, but I've another casual sexual partner, who we meet occasionally."

Another female participant describes her experience with inconsistent condom use: *"I have a friend,*

whom we had sex without using condom, therefore I think I am at risk of getting infected with HIV”.

Several participants perceived HIV infection to be deadly and a severe disease. Participants expressed fear of death and/or sexual disorders as serious outcomes following STI, including HIV. A male participant expressed his fear of HIV infection:

“The end of it [HIV infection] is death, because when you get HIV, it is okay that you will get drugs [ARV’s] which will make you feel better, but really you are no longer safe, it will reach a time those drugs [ARV’s] will no longer help you, you will stay in bed, that will be the end of it [life]”.

Beliefs on condom use

Most participants discussed several beliefs related to condom use, such as: religion, unfaithfulness, reduced sexual pleasure, fear of losing a partner, delays in ejaculation, and promotion of promiscuity.

Religious beliefs were reported to have a negative impact towards condom use. Both Christians and Muslims participants observed that it is against their faith to use condoms. A male participant explained: *“we Christians believe that, God created us to reproduce and fill the universe, bearing that condom was made to prevent unintended pregnancies, therefore it is a sin to use a condom. I will be unable to reproduce.”*

Another male participant explained: *“From our side we Muslims, sperms which remains inside a condom were expected to fertilize and produce pregnancy, therefore [using a condom] you are counted as a killer”.*

A male respondent in the FGD observed that condom use was a sign of untrustworthy: *“Trust will no longer be there because; a condom is used to protect against sexually transmitted infections. Now, if she tells you to use a condom, it means she doesn’t trust you, maybe she think you have already contracted diseases [STIs] so you may infect her”.*

Several respondents expressed concern that condoms reduce sexual pleasure. Some male participants explained how condoms reduce sexual pleasure *“when you put on a condom, you will not feel the pleasure, that is why the majority [youths] are motivated to have sex without using rubber [a condom] as they believe that a condom, will reduce sexual pleasure”.*

It was evident that fear of losing a partner has a

negative impact to condom use. Some female participants in FGD explained how this fear of losing a partner may hinder condom use:

“...another belief is fear of destroying a relationship because; if a man tells you ‘I don’t need to use a condom’ if you are not ready to destroy the relationship, you should agree not to use a condom”.

On the other hand, some male participants were more concerned with delayed ejaculation when using a condom. A male participant describes his experience the first time he had sex with a condom:

“My first sexual intercourse with a condom,, took me quite a long time to ejaculate”.

A concern that condom use promotes promiscuity was stated as a major predisposing factor to multiple sexual partnerships and casual sexual intercourse. A female participant explained that advocacy for condom use, cheaper price of condoms or free availability of condoms contributes to an increase in promiscuity:

“Because there are condoms which sell cheaply at 100 Tanzanian shillings, therefore someone can afford to buy and have sex with many people as s/he wishes”.

Perceived benefits

Perceived benefits of condom use were influenced by the protective effect of condoms against unwanted pregnancies, STI’s and HIV infection. A female respondent explained that consistent condom use has a strong protective effect:

“I understand that, if a condom is used properly, there will be complete protection against HIV. I believe, if I will use a condom I will prevent myself against HIV infection”.

A male respondent perceived that condom use has an effective protection against STIs, including HIV infection:

“I believe that, if I use a condom properly, I will protect myself against sexually transmitted infections, including HIV”.

A female respondent had this to say on perceived benefits of condoms: *“Apart from protection against STIs, including HIV, condom use also prevents unwanted pregnancy and serves in the whole issue of family planning.”*

Perceived barriers

Participants mentioned potential barriers which may hinder condom use. Having a regular partner was frequently reported as a psychosocial barrier to condom use. A female participant explained that having a relationship with someone for a long time in a sexual relationship builds trust, which leads to non-condom use:

“To my opinion, you can't use a condom if you have stayed together for a long time, it means you trust each other, and you may stop using a condom”.

Partner objection or unwillingness to use a condom due to lack of knowledge to condom efficacy was another psychosocial barrier to condom use. A female participant observed: *“men are resistant on using it [condom], they tell you that ‘a condom doesn't protect you 100 percent against HIV, I will not use it’. Once you agree with him you put yourself at risk of HIV infection”.*

Inability to use the female condom was identified as a common utilization-related barrier to condom use. A female participant explained how they face difficulties in proper use of the female condom:

“I can see the use of a female condom difficult, mostly if you want to use it by the time you are ready, bearing that there are a lot of processes like putting yourself into the right position, lifting up one leg, inserting a condom and so on, it may cause you to leave it and continue without using a condom, male condoms are better than female condoms”.

Self efficacy to condom use

Several participants observed that low self-efficacy has acted as a serious impediment for enabling decision-making in condom use. A female participant, described how lack of discussion on condom use prior to having sex, inability to ask a partner to use a condom, coerced sex and inability to refuse sex if a condom is not used impacts on non-condom use:

“If you don't discuss first and then you come with a condom, if your partner refuses to use, it becomes a conflict, since you are already in need of sex, you ought to do it without using a condom”.

Coerced sex was mentioned as another factor affecting self-efficacy to condom use. A female participant stated: *“You may refuse to have sex without a condom, but a partner may force you, a man doesn't fail, men are more powerful than women, therefore he will force you into sex”.*

Discussion

This study used the Health Belief Model (HBM) to assess factors associated with condom use among out-of-school youth in an urban setting. Our results showed high perceived vulnerability to/and severity of HIV infection among respondents. Although, it is difficult to assess differences in self-reporting perceived risk, yet respondents felt they were at risk of acquiring HIV infection. Women respondents based their vulnerability to the well established difficulty facing women in negotiating safer sex [2; 12].

As expected, religion was the most frequently mentioned belief against condom use. In fact, both Christians and Muslims agreed that their faith prohibits the use of condoms, since a condom interferes with procreation. These findings appear to be consistent with several studies on correlation between religion, which prohibits adultery, which help to protect against contracting HIV and condom use [19; 20]. However, strong religious beliefs do not always correlate with HIV protective behaviors, such as condom use and can be a significant source of negative perceptions about HIV and condom use [11; 21; 22].

Our study observed that females' participant had fear of losing a male partner if they insist on condom use in a sexual relationships. This finding is disturbing and could be a proxy measure of gender inequalities in relationships among youths and may make women vulnerable to acquire HIV infection. Hence it is important to consider gender inequality and negotiation skills as key strategies of HIV prevention interventions [13; 23; 24].

Generally, adolescents in this study tend to believe that a condom reduces sexual pleasure and this belief discourages condom use. Men, in our study, were more concerned regarding reduced pleasure and delayed ejaculation when using a condom. This is consistent with studies conducted elsewhere on non-condom use among sexually experienced youths [4; 14; 24; 25]. An intervention designed to increase motivation for condom use, while addressing this salient barrier may be an effective approach [4; 13; 26; 27; 28].

Among female participants in this study, inability to use a female condom was a common utilization-related barrier to condom use. This lack of skills in female's condom, is an important barrier to condom use [11; 22; 23], and underscores the importance of training youth proper condom use, particularly women.

In this study women were more likely than men to feel that they may engage in unprotected sexual relationship despite a high self-efficacy to

condoms. The observed gap between a high self-efficacy to condoms and the real practice of non-condom use may be explained by multiple factors, such as; lack of discussion on condom use prior to having sex, inability to ask a partner to use a condom/or refuse sex if a condom is not used, and coerced sex [11;25;28]. These findings are consistent with the HBM construct [15; 16] and suggest that perhaps a goal-oriented method of communication designed to potentiate readiness to condom use may be an effective approach [26].

Study limitations

This study has certain limitations. First, as a qualitative study, the findings are preliminary, descriptive in nature and causal associations can't be inferred. Second, given that this study was done in one location it may not be applicable to other settings. Third, despite efforts to recruit a wide range of participants, those who agree to participate may differ in significant ways from those who didn't participate. Lastly, the study used the HBM, a cognitive based model, which is limited in accessing the emotional component of behaviour.

Conclusions

Our findings supported some of the HBM constructs, such as perceived vulnerability and severity to HIV infection, perceived benefits and barriers, and cues for action for behavioral change for condom use among study participants in an urban setting. However, lack of negotiation skills for safer sex is a major impediment on condom use, particularly among women.

An effective behavior-change programme for HIV prevention, strategy should address psychosocial and utilization related barriers to condom use by putting emphasis on skills for correct condom use and negotiation for safer sex, particularly for women. Additionally, strategies based on increasing perceived vulnerability and/or severity to HIV infection, may influence condom use. The findings highlight the importance of cues for action/and self-efficacy to condom use as triggers to potentiate condom use in this age group. In conclusion, therefore, it is important that HIV intervention planners understand the importance of focusing on identified HBM constructs that have the greatest probability of influencing condom use by providing accurate information about benefits of condoms and skills to overcome HIV-risk behaviors in efforts to dispel barriers to condom use among out-of-school youths in Tanzania.

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References:

1. UNFPA (2009). Youth and HIV/AIDS Fact Sheet: State of the World population. Available at: http://www.unfpa.org/swp/2009/presskit/factsheets/facts_youth.htm. (Accessed on 15th August, 2012).
2. National Bureau of Statistics (NBS) (2002). Population and Housing Census 2002. General report. Dar es Salaam, Tanzania: National Bureau of Statistics.
3. Imanguli, N. (2008). Youth and the Global HIV/AIDS Pandemic. Advocates for Youth. Available at: <http://www.advocatesforyouth.org/storage/advfy/documents/fsglobalhiv.pdf>. (Accessed on 15th August, 2012).
4. UNAIDS/WHO (2010). AIDS epidemic updates. Geneva: Joint United Nations Programme on HIV/AIDS Available at: <http://www.who.int/whosis/en/>.(Accessed on 15th August,2012).
5. UNAIDS/WHO (2009). Epidemiological Fact sheet on HIV and AIDS. Available at: http://apps.who.int/globalatlas/predefinedReports/EF_S2009/full/EF_S2009_HT.pdf. (Accessed on 15th August, 2012).
6. Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC),NationalBureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), & Inc (2008). Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08, Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and Macro International Inc.
7. UNGASS/TACAIDS (2010). UNGASS reporting for 2010: Tanzania Mainland & Zanzibar. Available at: http://www.data.unaids.org/report/2010/Tanzania_2010_country-progress-report/em.pdf. (Accessed on 15th August,2012).
8. Calazans G, Dias R, Venturi G, Paiva V (2008). Age and condom use at first sexual intercourse of Brazillian Adolescents. *Revista de Saude Publica* , .42.
9. Alemu H, Belay K A , Davey G, Haile M

- D (2007). Factors predisposing out-of-school youths to HIV/AIDS related risky sexual behavior in North West Ethiopia. *The Journal of Health Population and Nutrition* 2007, 25(3), pp. 344-350.
10. Katapa R S , Lema L A and Musa A S (2008). Knowledge on HIV/AIDS and sexual behavior among youths in Kibaha District Tanzania. *Tanzanian Journal of Health Research* , 10(2), 12-18. Kinondoni Municipal Profile .Available at: <http://www.tanzania.go.tz>. (Accessed on 15th August, 2012).
11. Njau B , Mtweve S , Barongo L , Manongi R , Chugulu J and Msuya M. et al (2006). The Influence of peers and other significant persons on sexuality and condom-use among Young adults in northern Tanzania. *African Journal of AIDS research*, 5(3), 33-40.
12. Mazive E , Morris L , Prata N , Stehr M and Vahidnia F (2006). Relationship between HIV risk perception and condom use: Evidence from a population based survey in Mozambique. *International Family Planning Perspectives*, 32(4), 192-200.
13. Noar S M (2008). Behavioural interventions to reduce HIV-related risk behavior: Review and synthesis of meta-analytic evidence. *AIDS and Behavior*, 3, 335-353.
14. Muela S H , Ribera J M , Nyamongo I (2003). Health –seeking behaviour and health system response. *DCPP working Paper* No.14 , 3-37.
15. Champion VL, and Skinner C S (2008). The Health Belief Model. In: Glanz et al (eds). *Health Behavior & Health Education: Theory, Research and Practice*. 4th Edition: 989 Market Street, San Francisco, CA/United States of America. Jossey-Bass publication, 45-65.
16. Fisher J D and Fisher W A (2000). Theoretical approaches to individual-level change in HIV risk behaviours. In: J.L. Peterson & R.J. DiClemente (Eds.), *Handbook of HIV Prevention* (AIDS Prevention and Mental Health) pp.3-48. New York: Kluwer Academic/Plenum.
17. Spencer L , Ritchie J and O'Connor W (2003). Carrying out qualitative analysis. In: Ritchie J., Lewis, J. (eds). *Qualitative research practice: a guide for social science students and researchers*. London/Thousand Oaks, CA/New Delhi: Sage Publication.
18. Singleton R A and Stratis B C (2005). *Approaches to Social Research* (4th ed.): Oxford University Press, Inc.
19. Ragnarsson A , Onya H E and Aaro L E (2009). A young person understands of HIV: a qualitative study among school students in Mankweng, South Africa. *Scand J Public Health*, 37(2), 101-106.
20. Zou J , Yamanak Y , John M , Watt M , Ostermann J , Thielman N (2009). Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes. *BMC Public Health* , 9,75.
21. Agha S , Hutchinson P , and Kusantahn T (2006). The effects of religious affiliation on sexual initiation and condom use in Zambia. *J Adolesc Health*, 38(5), 550-555. ATLAS.ti Scientific Software Development GmbH, B.
22. Adebisi A O and Asuzu, M C (2009). Condom use among out of school youths in a local government area in Nigeria. *African Health Science Journal*, 9(2), 92-97.
23. Coates T J, Hendriksen E S, Lee S , Pettifor A , Rees H V (2007).. Predictors of condom use among young adults in South Africa: The Reproductive Health and HIV Research Unit National Youth Survey. *American Journal of Public Health* , 97(7), 1241-1248.
24. Lawonyin O O and Kanthula R M (2010). Factors that Influence attitudes and Sexual behavior among Constituency Youth Workers in Oshana Region, Namibia. *African Journal of Reproductive Health* , 14[1], 55-69.
25. Hounton S H , Carabin H , Henderson N J (2005). Towards an understanding of barriers to condom use in rural Benin using the Health Belief Model: A cross-sectional survey. *Biomed Central Journal* , 5 (8), 1471-2458. International Youth Foundation. Available at: <http://www.iyfnet.org/document.cfm/748>. (Accessed on 15th August, 2012).
26. Lauby J L , Bond L , Eroglu D and Batson H (2006). Decisional Balance, Perceived Risk and HIV Testing practices. *AIDS and Behavior*, Vol.10, No.1, doi: 10.1007/s 10461-005-9029-7.
27. Prochask J O (2006). Moving beyond the transtheoretical model. *Addiction*, 101, 768-778.
28. Outlaw A , Naar-King S , Janisse H , Parson J T and The Adolescent Trials Network for HIV/AIDS Interventions (2010). Predictors of Condom Use in a Multisite Study of High-Risk Youth Living with HIV. *AIDS Education and Prevention*, 22(1), 1-14.

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