

Trust, commitment, fidelity, and condom use among young adults in Tanzania

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For sexually active individuals there are two ways to avoid HIV infection: long-term fidelity with an uninfected partner or consistent condom use. Trust and commitment play a complex but critical role in both fidelity and condom use. While trust in and commitment to one's partner are often barriers to condom use (Agha, Kusanthan, Longfield, Klein, and Berman 2002), they are likely prerequisites for long-term fidelity. Research on the link between trust and condom use is emerging (Klein and Coombes 2005), yet the relationship between trust, commitment, and long-term fidelity has yet to be explored. In fact, of the three standard methods of AIDS prevention—abstinence, fidelity, and condom use—fidelity remains relatively under-researched. For HIV prevention to better address couples, trust, commitment, and the behaviors with which they are associated must be better understood.

Across a variety of cultures and historic periods a common response to risk is for individuals to identify the threat as not relevant for them—others are to blame and others are at risk (Joffe 1999). This response invokes the notions of individual and group identities in the form of “me,” “we,” and “them.” In a broader sense, this dissertation seeks to understand how individuals develop trust and commitment in a context where sexual relationships involve taking on risk. The formation of trust, commitment and a sense of we-ness is often studied in contexts where the potential costs of broken trust and commitment are less likely to be fatal. Developing committed and trusting relationships has an added layer of complexity for individuals living with the daily realities and risks of the African AIDS epidemic. Individuals in areas with generalized epidemics—those with an HIV prevalence rate of 5 percent or higher—can no longer identify risky partners as those in the traditional high-risk groups and must consider the possibility that any partner could be risky.

In sub-Saharan Africa the potential costs of broken trust and commitment include many of the same emotional and psychological costs individuals face in Western contexts, as well as the potential health costs of HIV infection. In a context where marriage is nearly universal and an important element in the transition to adulthood, individuals must manage their risk of infection through condom use or mutual fidelity with an uninfected partner. Requesting to use condoms often implies that either one or one's partner has been exposed to risk or cannot be trusted to keep the couple free from infection. This violates a sense of we-ness and may imply a

lack of commitment to the relationship. As such, while relying on mutual fidelity implies an element of we-ness, condom use implies an element of me-ness. It is in this context that we seek to understand how individuals come to trust and be committed to each other.

This research aims to improve our understanding of trust and commitment between couples and the relationship that trust and commitment have with fidelity and condom use using multiple theories (social exchange and identity) and multiple methods (semi-structured in-depth interviews and in-person survey interviews). Semi-structured in-depth interviews prior to the survey allowed the inclusion of unexpected local insights and ideas to our research and questionnaires for survey interviews. An in-person, household-based survey provides the empirical basis for testing and quantifying the relationship between the elements of trust, commitment, and preventive behavior—long-term fidelity and condom use. Finally, a second round of semi-structured in-depth interviews explore the nuances and questions raised in the analysis of the survey data and provide insights to the meaning of the findings.

BACKGROUND AND SIGNIFICANCE

This project uses concepts and theoretical perspectives from public health and two areas of sociology: demography and social psychology. Public health specialists have focused on abstinence, fidelity, and condom use for preventing HIV transmission in regions such as sub-Saharan Africa where heterosexual sex is the main means of transmission (UNAIDS 2004). With a median age at first sex of 17.3 years for Tanzanian women aged 25 to 29 and of 18.2 for Tanzanian men aged 25 to 29 as measured by the 2004 Tanzania DHS (ORC Macro 2006), many young adults no longer have abstinence as a way to prevent HIV infection. Youth aged 15 to 24 in Tanzania report are considered an important target for HIV prevention due to their risky sexual behavior and, particularly at younger ages, their relatively low rates of HIV infection. The HIV prevalence, as measured by the 2003-2004 Tanzania HIV/AIDS Indicator Survey (THIS), is 2.1 percent for Tanzanians aged 15 to 19 (Tanzania Commission for AIDS (TACAIDS), National Bureau of Statistics (NBS), and ORC Macro 2005). The prevalence among those aged 20 to 24 is 5.2 percent. While a prevalence of 5.2 percent is not low in absolute terms, it is much lower than the 10.8 percent of adults aged 30 to 44 who are HIV positive. Despite the relatively low HIV prevalence among youth, according the 1996 TDHS, women aged 15 to 19 and men aged 20 to 24 reported the highest rates of having multiple or non-regular partners (of women aged 15 to 49 and men aged 15 to 59) (Kapiga and Lugalla 2002).

For young adults in sub-Saharan Africa, the main reason for not using condoms is trusting their partner (Agha et al. 2002; Plummer, Wight, et al. 2006). Focus group discussions on the meaning of trust and how it interferes with condom use among young adults in various urban centers in the region, including discussions in Dar es Salaam, suggest that young people refer to a partner's general characteristics and behaviors to determine whether that partner is deserving of their sexual trust (Longfield, Klein, and Berman 2002). A generalized interpersonal trust in one's partner reduces the feelings of risk despite not knowing a partner's sexual history or HIV status. Partners feel safe because they generally "trust" that their partner has goodwill toward them and would not intentionally infect them.

Fidelity is a relatively under-researched element of AIDS prevention and the determinants of fidelity remain relatively unknown. Marriage, a research area long-studied by demographers, is assumed to be protective against HIV. Although multiple partnerships tend to be underreported, in urban areas of Tanzania, 12% of married couples are discordant, that is, one partner is HIV positive while the other is not. Further, the percent of cohabiting couples throughout Africa that are discordant cannot be overlooked—they make up 7.3% of couples in urban Cameroon (Institut National de la Statistique (INS) and ORC Macro 2004) and 11.3% of couples in Kenya (Central Bureau of Statistics (CBS) [Kenya] 2004).

THEORETICAL PERSPECTIVES ON TRUST AND COMMITMENT

Researchers often hesitate to use Western theories in the African context. However, various social psychological models of health behavior have proven effective predictors of health behavior in sub-Saharan Africa, when adapted to the local context. For example, Derogatis' measure of distress has been used throughout the world, including by Dyer and colleagues (2005) in South Africa to study women who suffer from infertility's psychological distress. Perkel (1992) developed and tested an AIDS Psychosocial Scale in South Africa that included factors such as self-concept, rationalization, peer pressure, locus of control, and self-efficacy. Results show that the scale was both reliable and valid in this context. Based on the success of past research in using social psychological models of health behavior, two dominant social psychological perspectives that address trust and commitment guide this analysis: one based in social exchange theory (Homans 1961; Leik and Leik 1977; Sprecher 1988; Sprecher 2001) and one based in identity theory (Burke and Stets 1999).

Social exchange theory and identity theory are the dominant social psychological perspectives that address trust and commitment. Both theories start from the base that establishing commitment involves “[d]eciding that one’s partner is so essential that alternatives will not even be noticed” (p 308) and alternatives to the current relationship are not monitored.

In the self-verification process, positive self-feelings emerge when there is congruence between self-meanings and inputs from the environment. When there is not congruence between self-meanings and inputs from the environment, a feeling of distress emerges. Burke and Stets argue that taken together, the self-verification process and the emotions emerging from the process influence the level of trust in one’s partner. Finally, higher levels of trust in one’s partner are associated with commitment, emotional attachment, and a group orientation.

Both social exchange theory and the self-verification process suffer from difficulties in proving causality. For example, while negative emotions emerge from failure to verify one’s spousal identity, that failure to verify the identity may be due to low levels of commitment to one’s spouse identity in the first place. Both theories are limited in their discussion of the external constraints on individuals. For example, if having one’s father identity verified relies on one’s wife signaling that one is a good financial provider, the ability to have the father identity verified is also closely tied to one’s desirability on the job market. This is not accounted for in the self-verification model.

Results

Multivariate regressions using data from the pilot¹ show that greater trust in a partner is associated with positive self-feelings of higher self esteem, lower depression and distress. Commitment is associated with lower levels of distress and higher relationship satisfaction.

Multivariate logistic regressions show that condom use has an inverse relationship with commitment and marital status. Multivariate logistic regressions show that fidelity is associated with lower mastery, worse health and being female.

¹ Note that the data for the full survey are currently being entered. This analysis is of the 100 respondents who participated in the pilot survey. We will have the full dataset (n=2000) May 4th, 2007.