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The Influence of Intrapersonal Constraints on Travel Intention of People at High Risk from COVID-19 during the New Normal

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Abstract

Due to the COVID-19 pandemic, tourism constraints have created a challenge for inclusive tourism, especially for older people and people with comorbidities. This study examined intrapersonal constraints' effect on the travel intentions of people facing fewer opportunities for tourism due to the COVID-19 pandemic, which could disrupt their well-being fulfillment. The data were collected through an online survey of Jakarta citizens aged 46 years and older from the end of June to September 2021, and a total of 337 responses were accumulated. This study applied partial least square structural equation modeling to test the moderating effect of intrapersonal constraints toward the theory of planned behavior and revealed that the travel intentions of people at high risk from COVID-19 were considered high and were directly influenced by subjective norms, perceived behavioral control, and intrapersonal constraints. High travel intention implies that intrapersonal constraints do not extensively weaken at-risk people's desire to travel during the new normal.

Keywords: constraint, COVID-19, intention, theory of planned behavior, tourism

Introduction

Human try to achieve well-being in variety of ways, one of them is tourism. In addition, an interrelatedness has been well established between travel, tourism, and health, as supported by the view that tourism experiences can have both physical and mental health benefits.[1] This is in line with statements by the United Nations World Tourism Organization,[1] acknowledging that tourism can contribute to health and well-being in various indirect ways. The World Health Organization (WHO),[2] has defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." In addition to improving well-being, travel is also considered a basic need and right, as it is known that everyone is entitled to the same rights of leisure, rest, and freedom.[3]

Currently, world tourism activity is suffering from a decline due to the spread of the novel coronavirus disease 2019 (COVID-19). As of November 23, 2021, Indonesia recorded an 83.2% casualty of people aged 46 years and older.[4] Therefore, that age group can be considered vulnerable to COVID-19. This is supported by a statement by epidemiologists which is the immune system, cell regeneration speed, and organ function of people aged 45 years and older are not as good as those of younger people, and thus, the body is more susceptible to disease.[5] This group is classified as older people and consists of middle age (45–59 years old) and the elderly (60 years old and above).[6]

In addition to the risk of transmission, the drive in the economic sector urged the Indonesian Government to implement policies for the transition period known as the "new normal." This condition refers to the presence of a new order in response to crises and includes a form of change and adaptation of new systems to prevent reoccurrence or to prepare for a crisis.[7] The New Normal Policy means learning to live with COVID-19 by implementing strict health protocols in various activities,[7] including tourism. This policy in Indonesia was introduced in June 2020 with adjustments in the intensity of people's activities based on the COVID-19 positivity rate.[8] Rationally, the "new normal" will become "normal" when the world has come to terms with the pandemic and it becomes endemic.[9] This policy was initiated by the tourism sector in the Cleanliness, Health, Safety, and Environmental Sustainability (CHSE) program for each

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tourism subsector.[10] The CHSE programs contain guidance to rerun the tourism sector by prioritizing sanitation, hygiene, and services without direct contact for mutual security in the form of certification within the tourism industry.[10]

Restarting tourism requires alteration, and as the industry prepares for this transformation, consumers must also change in light of the pandemic in terms of their perceptions, preferences, and attitudes toward traveling—and tourism industries must be prepared for those changes.[11] People aged 46 years and older have a high potential for traveling. In the pre-pandemic era, this age group contributed to the most increased average length of stay and travel expenditure.[12] However, their vulnerability to COVID-19 may limit their choices for safe spaces outside the home. These obstacles to traveling can interfere with their fulfillment of well-being. Intrapersonal constraint, including health, has been assumed to be one's most powerful constraint, as it determines the motivation for participation.[13] It then becomes the most effective constraint in the pre-contemplation stage.[14] Constraints in the form of fears and anxieties associated with uncertainty may negatively influence people's intention to visit destinations or even cause resistance to travel to destinations.[15]

Studies on travel intention during the COVID-19 pandemic have been growing. However, studies related to travel and people at risk of COVID-19 have been slightly overlooked. Wachyuni and Kusumaningrum,[16] found that millennials' post-pandemic travel intention in Jakarta is higher than their travel anxieties. Graham, *et al.,*[17] investigated the elderly's air travel intention during the pandemic and found that more than 50% plan to travel within one year after the pandemic. However, the age cluster used did not show significant behavioral variation. The authors recommended that future study will include older people of younger ages who have physical vulnerabilities toward COVID-19,[17] and this study intended to accommodate this recommendation. Concerning constraints and travel intention, Andreani and Njo,[18] used the theory of planned behavior (TPB) framework to analyze the effect of travel constraints on travel intention. They found that intrapersonal and structural constraints significantly influence travel intention. However, their study did not group respondents or specifically looked at the pandemic context.

In TPB, the intention is a direct determinant of behavior, and intentions are influenced by attitudes toward behavior, subjective norms, and perceived behavioral control (PBC).[19] Attitudes toward behavior indicate an individual's tendency toward a particular view of behavior; subjective norms indicate the amount of social pressure from individual or group referents that encourage a person's participation in certain behaviors, while PBC indicates how easy or difficult it is to carry out the behavior with the resources one has.[19] Aiming to understand the effect of intrapersonal constraints on travel intention of people at risk from COVID-19 during the new normal, this study added intrapersonal constraints in the TPB framework, where attitudes, subjective norms, and PBC were independent variables, travel intention was the dependent variable, and intrapersonal constraint was the moderator variable. This study proposed seven hypotheses. The first hypothesis (H1) was that attitude significantly influences travel intention. The second hypothesis (H2) was that subjective norms significantly influence travel intention. The third hypothesis (H3) was that PBC significantly affects travel intention. The fourth hypothesis (H4) was that intrapersonal constraints significantly influence travel intention. The fifth hypothesis (H5) was that intrapersonal constraints significantly moderate the relationship between attitude and travel intention. The sixth hypothesis (H6) was that intrapersonal constraints significantly mediate the relationship between subjective norms and travel intention. The last hypothesis (H7) was that intrapersonal constraints significantly moderate the relationship between PBC and travel intention.

Method

The population of this study was the ones physically vulnerable to COVID-19 in DKI Jakarta Province. Purposive convenience sampling was applied, with the sample criteria including citizens of the five Jakarta municipalities aged 46 years and older. The number of participants was drawn according to the rules that the appropriate sample size for research, in general, should be 30 to 500, with a minimum size of 30 for each category.[20] Kline stated that a minimum sample for structural equation modeling (SEM) should be around 100 to 200, while Tabachnick and Fidell recommended a minimum sample of 300 for statistical data analysis.[21] Hence, to meet the general requirements of a research sample and those for statistical data research using SEM, this study set a minimum sample of 300 respondents. In detail, the sample was divided into four groups based on their age and health condition: the elderly, with and without comorbidities, and the middle-aged, with and without comorbidities.

Data were gathered using Google Forms circulated via WhatsApp messages to support physical distancing, and respondents were allowed to complete the form at their convenience. Following Ajzen's suggestion, an eliciting questionnaire was conducted during the first data collection stage.[22] A pilot study completed by 30 respondents was undertaken in mid-June 2021, and all variables were confirmed to be valid and reliable—the final questionnaire comprised three parts. The first part was the respondents' profile, which consisted of demographic

characteristics and health conditions. The second part included multiple-choice statements concerning the TPB variables: attitudes (five indicators, e.g., "Traveling during the new normal is more convenient"), subjective norms (five indicators, e.g., "Most of my friends think positively about traveling during the new normal"), PBC (five indicators, e.g., "I have enough free time to travel during the new normal"), and travel intention (three indicators, e.g., "I feel excited to travel during the new normal"). The third part included multiple-choice statements on intrapersonal constraints (five indicators, e.g., "I am worried that I may get infected by COVID-19 while traveling during the new normal"). The second and third parts were assessed using a four-point Likert scale (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree). It has been suggested that research in Indonesia should apply an even Likert scale, as Indonesians are relatively inclined to take a neutral side.[23]

The International Business Machines Corporation (IBM) Statistical Package for the Social Sciences (SPSS) for Windows, version 25 (IBM Corporation, Armonk, New York, United States of America) was used to calculate the percentage of respondents in the profile. Demographic information consisted of age, gender, marital status, education, and occupation, while health conditions included perception of comorbidities. Age was categorized based on the definition mentioned above. Marital status was divided into two categories. Married people were considered those who still had either a spouse and/or children, while single people were considered those who had neither a spouse nor children. This classification was aimed to distinguish people who had attachments to a nuclear family from those who did not. Education was classified based on graduation level, from elementary to postgraduate. Finally, occupation was divided into people still dynamically earning money (entrepreneur, employee) and those who did not (retired, housewife, unemployed).

The first step was the outer model evaluation, which was performed by checking the convergent validity (shown by the average variance extracted/AVE and outer loading value more than 0.5), discriminant validity (based on Fornell and Lacker's criterion, shown by the AVE root of a variable that is higher than the correlation of the variable with other variables), and the reliability of the variables (proven by the value of the composite reliability more than 0.7).[24] In determining the tendency of the response, the level of respondents' achievement (LRA) and the mode of response were referred to. Descriptive statistics were used to find the mean for each indicator to calculate the LRA, which was interpreted by using the following criteria: very low (0–20.99%), low (21–40.99%), moderate (41–60.99%), high (61–80.99%), and very high (81–100%).25 The mode of response was used to determine the Likert scale that the respondents were most inclined to. After the model was specified, the hypotheses were verified by comparing the t table and t statistics values and considering the p-value. If the t statistics value was more than t table (with a confidence level of 0.05, it should be more than 1.96), and if the p-value was less than 0.05, then the hypothesis was accepted.[24] The inner model evaluation was performed next by finding the value of 1) Q2 to determine the model's predictive relevance (with a value more than 0 proving it) and 2) R^2 to determine the model's predictive ability (0.25 = weak, 0.5 = moderate, and 0.75 = significant).[24]

Results

The data collection resulted in 337 responses, more than the minimum sample number set for the study. The profile of the respondents is presented in Table 1. After deletion of the lowest outer loading, the model reached convergent and discriminant validity for 22 indicators. The model was also confirmed to be reliable according to the required AVE and composite reliability values. Table 2 shows that the group of middle-aged individuals without comorbidities had high LRAs and "agree" modes for all variables. The group of middle-aged individuals with comorbidities had relatively similar LRAs and mode results, except they had lower social pressure to travel during the new normal.

Table 3 shows that, overall, the elderly without comorbidities had high LRAs, except for in the subjective norm category. Next, although the elderly with comorbidities have a higher risk of COVID-19, they have a high level of travel intention. However, they also have very high intrapersonal constraints and demonstrate a lower attitude and pressure to travel in the new normal.

Table 1. Respondents' Profile

Demography/Condition	Category	n (n = 337)	%
Age	46–59	269	79.8
	>60	68	20.2
Sex	Male	110	32.6
	Female	227	67.4
Marital status	Married	299	88.7
	Single	38	11.3
Education	Elementary & junior high	12	3.6
	Senior high	83	24.6
	Associate's degree	35	10.4
	Undergraduate	139	41.2
	Graduate/postgraduate	68	20.2
Occupation	Employee	158	46.9
	Entrepreneur	34	10.1
	Retired	50	14.8
	Unemployed	12	3.6
	Housewife	83	24.6
Having comorbidities	Yes	97	28.8
	No	240	71.2

The structural model testing in Table 4 proved that H2, H3, and H4 were supported and resulted in the structural model depicted in Figure 1. The model resulted in a Q2 of 0.494, meaning that it has predictive relevance. Next, an R2 value of 0.701 was found, which falls into the category of moderate, close to being significant. This result showed that travel intention was influenced by subjective norms, PBC, and intrapersonal constraints as much as 70.1%, while other aspects excepted from this study have a share of 29.9% of effects on travel intention.

Discussion

Previous studies have shown that intrapersonal constraints have a significant negative influence on travel intention.[18,26] This study also found a similar result, which means that people at high risk from COVID-19 realized the importance of considering their age and physical condition when traveling during the new normal. The influence of respondents' physical condition on their psychological condition might affect their plans to travel during the new normal. High constraints justified at-risk people's attitudes regarding the inconvenience of traveling in the new normal.

Studies on travel intention in the TPB framework have shown that attitude significantly and positively influences travel intention.[27-30] However, this study noticed that attitude had no significant influence on travel intention when intrapersonal constraints were considered in the framework. This discrepancy might be caused by the different populations studied, as most of the respondents in previous studies were under 46 years old.[27-29] The contrast might also be due to different variables added in the TPB framework, as none of the other studies

Table 2. Middle-Aged Group's Level of Respondents' Achievement Regarding Theory of Planned Behavior and Intrapersonal Constraints

Health Condition	Category	AT (%)	SN (%)	PBC (%)	TI (%)	IC (%)
Without comorbidities (n = 210)	LRA	65.4 (H)	62.6 (H)	70.8 (H)	69.4 (H)	72.1 (H)
	Mode	A (42.4)	A (40.5)	A (47.6)	A (44.8)	A (33.3)
With comorbidities (n = 59)	LRA	64.5 (H)	60.3 (M)	70.3 (H)	65.9 (H)	77.9 (H)
	Mode	A (35.6)	A (35.6)	A (54.2)	A (42.4)	A/SA (39)
Total (n = 269)	LRA	65.2 (H)	62.1 (H)	70.5 (H)	68.7 (H)	78.0 (H)
	Mode	A (40.5)	A (39.4)	A (49.1)	A (44.2)	A (34.6)

Notes: AT = Attitude, SN = Subjective Norms, PBC = Perceived Behavioral Control, TI = Travel Intention, IC = Intrapersonal Constraints, LRA = Level of Respondents Achievement, M = Moderate, H = High, A = Agree, SA = Strongly Agree.

Table 3. Elderly Group's Level of Respondents' Achievement toward Theory of Planned Behavior and Intrapersonal Constraints

Health Condition	Category	AT (%)	SN (%)	PBC (%)	TI (%)	IC (%)
Without comorbidities (n = 30)	LRA	66.8 (H)	60.8 (M)	72.3 (H)	67.2 (H)	73.4 (H)
	Mode	A (40.0)	DA (43.4)	A (36.7)	A (36.7)	A/SA (40)
With comorbidities (n = 38)	LRA	59.1 (M)	58.4 (M)	68.3 (H)	61.4 (H)	82.9 (VH)
	Mode	DA (47.4)	DA (50.0)	A (50.0)	DA (36.8)	SA (44.8)
Total (n = 68)	LRA	62.5 (H)	59.5 (M)	70.3 (H)	63.9 (H)	80.7 (H)
	Mode	DA (41.2)	DA (47.1)	A (44.1)	DA (36.8)	A (42.6)

Notes: AT = Attitude, SN = Subjective Norms, PBC = Perceived Behavioral Control, TI = Travel Intention, IC = Intrapersonal Constraints, LRA = Level of Respondents Achievement, M = Moderate, H = High, VH = Very High, DA = Disagree, A = Agree, SA = Strongly Agree.

Table 4. Hypotheses Testing Results

Relationship	Original Sample	T Statistics	p-values	Remarks
H1: AT → TI	0.083	1.201	0.230	Not significant
H2: SN → TI	0.277	4.153	0.000	Significant
H3: PBC → TI	0.475	9.554	0.000	Significant
H4: IC → TI	-0.151	4.025	0.000	Significant
H5: Moderating Effect of IC on AT → TI	-0.046	0.923	0.356	Not significant
H6: Moderating Effect of IC on SN → TI	0.067	1.327	0.185	Not significant
H7: Moderating Effect of IC on PBC → TI	-0.018	0.386	0.700	Not significant

Notes: AT = Attitude, SN = Subjective Norms, PBC = Perceived Behavioral Control, TI = Travel Intention, IC = Intrapersonal Constraints.

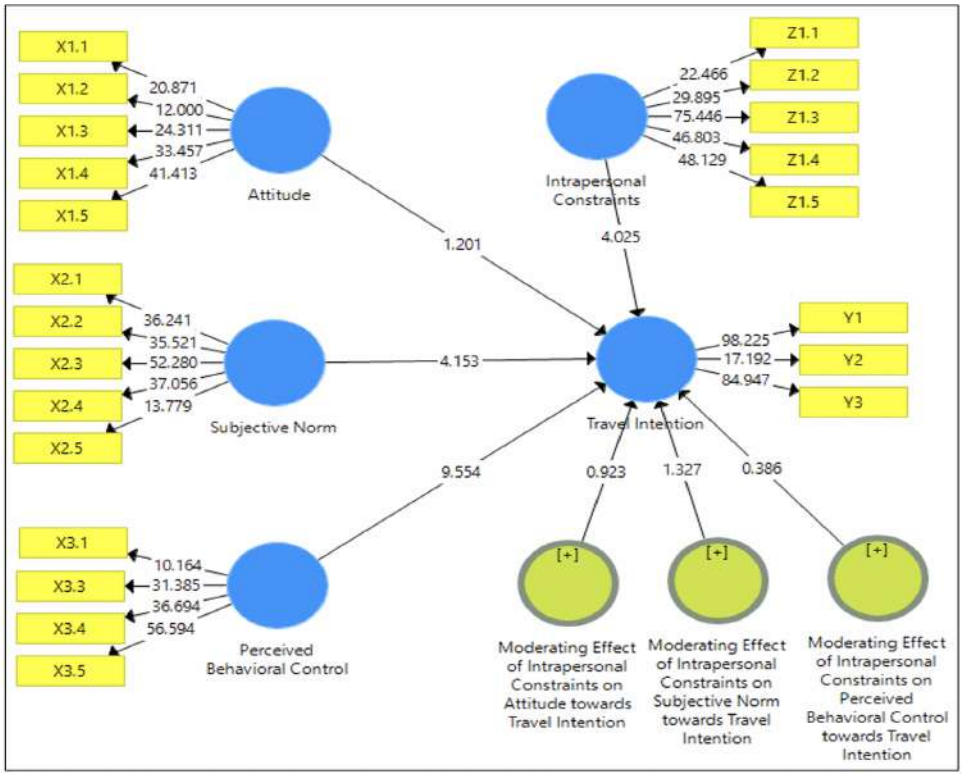


Figure 1. Partial Least Square Structural Equation Modeling Result

included intrapersonal constraints.[27-30] Finally, it might also be because the previous studies were conducted in the first semester of 2020 when the new normal was just deliberated or implemented.[27-30] The insignificant role of attitude implied that a good or bad view on traveling during the new normal does not influence the travel intention of people at risk from COVID-19. This condition might also be why intrapersonal constraints do not exhibit moderating effects on attitude toward travel intention, indicating that attitude is not shaped by one's condition but by the activity itself.

Similar to this study, previous studies have shown that subjective norms have a significant and positive influence on travel intention.[28-30] Respondents' answers showed that their persons or group referents do not encourage them to travel during the new normal. People seem to mind a great deal about each other's health. The presence of collective resilience could cause this, and a shift to prosocial and responsible consumption urged by the pandemic.[31,32] Collective resilience has thus also been a buffer toward intrapersonal constraints, causing intrapersonal constraints to be an insignificant moderator of subjective norms toward travel intention.

This study showed that PBC has a significant and positive influence on travel intention, and previous studies stated the same.[27-30,33] Furthermore, this study found that, among the TPB variables, PBC has had the most significant influence on travel intention during the pandemic, indicating the confidence of at-risk people in their capacity to travel during the new normal, supporting the previous studies.[27,33] The insignificant moderating role of intrapersonal constraints on PBC toward travel intention in this study could be caused by the high PBC, meaning that they believe they can find negotiating strategies for the constraints in traveling during the new normal.

This study found that the travel intention of people at high risk from COVID-19 belongs to the high category, with the middle-aged group having a higher LRA than the elderly. However, although the elderly's travel intention belongs to the high category, their mode of answering falls into the "disagree" scale, which hints at a hesitation to travel during the new normal, especially for the elderly with comorbidities. This finding supports a previous study revealing that elderly tourists have a high sensitivity toward health crises.[15] While intrapersonal constraints belong to a high level, and they do not necessarily lead to low travel intention. This could be explained by the respondents' high PBC. Otherwise, this could also indicate that respondents deem traveling very important in fulfilling their needs and improving their quality of life.

In any case, high intrapersonal constraints imply inconvenience in traveling during the new normal. Safety

is "the new comfort" during the new normal. Hence, the application of hygiene and sanitation factors against COVID-19, such as personal protective equipment, health education, personal hygiene, and sanitation, to prevent transmission,[34] and make traveling safer and more convenient. Tourism activities should then refer to CHSE implementation. In addition, "untact" tourism, such as healing ecotourism, staycations, and road trips, has become quite popular to satisfy the thirst for tourism while also minimizing the health risk from COVID-19 and may be a solution for people at risk.[35] However, considering the price, experience, and technology applied,[35] it is necessary to ensure its inclusivity. The untact culture was introduced to respond to the individualist tendency of modern people.[35] To prevent exclusivity, it is suggested that untact tourism services in Indonesia have a range of affordable prices, provide tourism experiences preferred by all segments, and feature a user-friendly service.

This study theoretically contributes by filling the tourism and pandemic literature gap that has not widely discussed at-risk people's behaviors. This study may belong to the initial studies on tourism consumption during the new normal in Indonesia from the standpoint of vulnerable people. It also expands TPB with the involvement of intrapersonal constraints by providing a more stable ground for explaining travel intention during a health crisis. The study offers several practical implications. First, it is necessary to lessen the psychological barriers of people at risk to travel during the new normal while balancing the effort to deal with a high travel intention by enhancing safety in traveling during the normal. In addition, it is also essential to ensure the accuracy and timeliness of information delivery in efforts to improve safety in activities during the pandemic to prevent overconfidence due to misinformation that could lead to higher vulnerability. Finally, tourism industries should also encourage visitors' responsible behavior by monitoring conformity to the rules.

This study has some limitations. First, there was an imbalance regarding the proportion between respondents' ages due to the type of sampling and data collection mechanism. However, besides performing SEM analysis, LRA calculation, which separates the results between the elderly and middle-aged respondents, is expected to minimize bias. Future studies can find a better data collection technique during the new normal and thus obtain a proportional sample. Second, questionnaires were distributed during Indonesia's second peak of COVID-19 transmission. Therefore, performing the study when the positivity rate is stably low could yield a different result. However, the data collection period covered the time when cases were rising until they flattened at the end of September 2021. Next, future studies can assess the tourism behaviors and coping strategies of at-risk people during the new normal as well as their trust perception of health protocol implementation by tourism industries.

Conclusion

Intrapersonal constraints directly influence the travel intention of people at risk from COVID-19. Yet, this study found that they do not moderate the relationship between attitude and travel intention, subjective norms and travel intention, or PBC and travel intention. In addition, high intrapersonal constraints do not necessarily lead to low intention to participate in tourism activities. Tourism authorities are recommended to encourage consistency with CHSE implementation and adopt and promote inclusive untact tourism to enhance the safety and convenience of traveling during the new normal.

Abbreviations

COVID-19: Coronavirus Disease 2019; H1: Hypothesis 1 (and so on); AT: Attitude; SN: Subjective Norm; PBC: Perceived Behavioral Control; TI: Travel Intention; IC: Intrapersonal Constraints; SEM: Structural Equation Modeling; TPB: Theory of Planned Behavior; SPSS: Statistical Package for the Social Sciences; LRA: Level of Respondents' Achievement; AVE: Average Extracted Variance; N: Total Number of Individuals in the Sample; M: Moderate; H: High; DA: Disagree; A: Agree; SA: Strongly Agree.

Ethics Approval and Consent to Participate

Electronic informed consent was distributed inclusively with the data collection instrument. Consent was obtained from all respondents prior to their starting to give responses. Therefore, respondents could withdraw from the survey at any moment without providing any justification.

Competing Interest

The author declares that there is no significant competing financial, professional, or personal interest that might have affected the performance or presentation of the work described in this manuscript.

Availability of Data and Materials

Authors clarify sources of data or information used as study materials.

Authors' Contribution

DW developed and designed the research and directed the overall work. IKW collected the data, performed the analysis, and wrote the first draft of the manuscript. Both authors discussed the results and contributed to the final manuscript.

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