Recall, relevance and application of an in-school sexual and reproductive health intervention 7–9 years later: perspectives of rural Tanzanian young people

JOYCE WAMOYI1*, GERRY MSHANA1, AOIFE M. DOYLE2 and DAVID A. ROSS2

1National Institute for Medical Research, Mwanza, P.O. Box 1462, Mwanza, Tanzania 2Department of Infectious Diseases Epidemiology, London School of Hygiene and Tropical Medicine, London, UK

*Corresponding author. E-mail: jwamoyi@hotmail.com

SUMMARY

Many adolescent sexual and reproductive health (ASRH) interventions have improved knowledge and reduced reported sexual risk behaviours, but found no impact on HIV. We explored potential reasons for this in 23 in-depth interviews, conducted 7–9 years after exposure to ASRH intervention. We discussed participants' memories and views of the relevance of the in-school intervention, and their subsequent ability to apply what they had learned. While most participants had favourable memories of the intervention, few recalled specific details. Most reported that the intervention had been relevant, although few reported being able to apply the teachings. Men found it easier to apply lessons about condoms than women. Inability to apply the intervention teachings was often linked to cultural norms around fertility and/or gender power relations. ASRH interventions should address structural factors such as the quality of parenting and explicitly link interventions to young peoples' future aspiration.

Key words: young people; HIV; reproductive health; sexuality education; Tanzania

INTRODUCTION

Many young people in sub-Saharan Africa (SSA) are at high risk of undesirable sexual and reproductive health outcomes such as unplanned pregnancy, HIV and other sexually transmitted infections (STIs). Numerous behavioural interventions aiming to improve adolescent sexual and reproductive health (ASRH) have been implemented and evaluated (Gallant and Maticka-Tyndale, 2004; Dick et al., 2006; Obasi et al., 2006; Cowan et al., 2008). However, despite these interventions, young people often express difficulty in taking the necessary measures to protect their health (MacPhail and Campbell, 2001; Wight et al., 2006; Wamoyi et al., 2011) and many continue to report multiple sexual partnerships, transactional sex and low levels of condom and contraception use (Vishra et al., 2009).

MEMA kwa Vijana (MkV) was one such ASRH intervention that was implemented between 1999 and 2002 in rural Mwanza, Tanzania, within a cluster randomized trial. It consisted of four components: a teacher-led, peer-assisted primary school curriculum; youth-friendly health worker training; a condom promotion-distribution initiative and supportive community-wide interventions (Obasi et al., 2006). The sexual behaviour goals of the intervention were abstinence (including delay of sexual debut), reduction of sexual partners and increased condom use. Other behavioural goals were early recognition and treatment seeking.
for symptoms of STIs and increased uptake of family planning services. There were also sessions that focused on shifting gender norms such as ‘girls and boys have equal abilities’ and ‘respecting other people’s decisions’. The specific topics covered by the in-school health education component of the intervention are shown in Box 1. MkV had a qualitative research component, the Health and Lifestyle Research (HALIRA) Programme, which focused on process and qualitative evaluation of the intervention activities, alongside general research on ASRH (Plummer et al., 2007).

### Box 1. Topics Covered during the MEMA kwa Vijana In-School, Teacher-Led Peer-Assisted Sessions
(approximately 12 forty-minute sessions per school year)

#### Year 5
1. What is reproductive health and why is it important?
2. Leaving childhood: Puberty
3. What are HIV and AIDS?
4. The facts about AIDS
5. The facts about sexually transmitted diseases
6. Girls and boys have equal abilities
7. Misconceptions about sex
8. Refusing temptations
9. Saying no to sex
10. Sexually transmitted diseases: Going to the clinic

#### Year 6
1. Review of last years’ learning
2. How HIV infection causes AIDS
3. How sexually transmitted diseases are spread
4. The relationship between HIV and sexually transmitted diseases
5. Reproductive organs and their functions
6. Pregnancy and menstruation
7. Respecting other people’s decisions
8. Recognising and avoiding temptations
9. Protecting yourselves: What are condoms?
10. Revision

#### Year 7
1. Review of previous years’ learning
2. How to avoid HIV infection and AIDS
3. Sexually transmitted diseases and their consequences
4. Making good decisions
5. Practising saying ‘No’
6. Being faithful
7. Achieving your future expectations
8. Planning for your future
9. Protecting yourself: Correct use of condoms & the truth about condoms
10. Revision

**Source:** Teachers’ guides accessible at [http://www.memakwavijana.org](http://www.memakwavijana.org)

The MkV trial showed that it was feasible for government education and health systems in SSA to implement ASRH interventions to a high standard. However, this intervention did not, in the short-term, have any significant impact on biological outcomes such as rates of HIV, other STIs and adolescent pregnancies (Ross et al., 2007). A key question remained as to whether such interventions could have a more beneficial impact in the longer term, following the exposure of multiple cohorts of young people to the intervention. A 2007–2008 cross-sectional survey, within the randomized trial design, evaluated the long-term impact of the MkV intervention among young people aged 15–30 years (Doyle et al., 2010). The results of this survey showed that, in the longer term, the intervention had still increased young people’s knowledge, reported attitudes and some, but not all, reported sexual risk behaviours, but that there had been no significant effect on the prevalence of HIV, other STIs or reported pregnancies. This rigorous evaluation revealed a disconnect between young people’s knowledge and their actual risky sexual behaviour, as measured by biological evidence of STIs, including HIV and their reported pregnancy rates. It is likely that other underlying factors (Wight et al., 2006; Wamoyi, 2008), more powerful than the intervention, had a greater influence on young people’s lives.

In the context of ASRH in SSA, there are few studies that have explored young people’s views about the relevance of the teachings of a given ASRH intervention targeted at them (Jewkes et al., 2010). There is also a paucity of data on the perspectives of young people on why they may or may not apply some of the ASRH knowledge acquired. In order to develop and implement more effective ASRH programmes, it is important to understand why knowledge of risk is not translated into desirable behaviour change. Using qualitative methods, this study explored young people’s memories and views of the relevance of the in-school component of the MkV intervention, and their ability to apply what they had learned 7–9 years after exposure to the intervention. It was hoped that this would shed light on why the MkV intervention did not have a significant impact on HIV, STIs and pregnancies.
METHODS

This qualitative study was conducted in 2009 in rural Mwanza, Tanzania. Data collection and analysis were done concurrently.

Data collection

In 1999, the original 120 HALIRA participants had been selected from the MkV cohort, with over-sampling of young people with biological markers of sexual activity (HIV positive or pregnant). In-depth interviews (IDIs) were conducted in 1999, 2000 and 2002. For the current study, a sample of 30 young people (15 males and 15 females) were selected, to equalize the number of males and females, from the 32 (15 males and 17 females) intervention arm participants who had participated both in the MkV 2007–2008 follow-up survey, and in at least one of the previous rounds of HALIRA IDIs. Out of the 30 young people selected, only 23 were available for the IDIs (11 males and 12 females). Among the seven missed, three were deceased (two women and one man), while four had migrated outside the study area and were not accessible.

The interviews were conducted in three phases with information and experiences in the initial phases used to inform data collection in the next phases. In the first phase, 10 interviews were conducted (five males and five females). These were analysed before proceeding with the second and third phases. In the second and third phases, 13 interviews (six males and seven females) were conducted. Prior to second phase, the wording and ordering of questions were revised based on the experiences in the first phase. The third phase, involved more focused data collection with emphasis on data that had not been adequately collected in the first two phases but were relevant to the research question.

Selected participants were located using their residence as recorded during the 2007–2008 survey, information from their previous HALIRA programme IDIs, trial records of the identity of their father, through their previous primary school and through contacts with other young people, village officials, teachers and other community members.

Data were collected on young people’s sexual histories and their perceptions of the importance of the MkV interventions and other influences in their lives. In particular we asked what young people recalled from the MKV intervention, whether what they had learnt from the intervention had influenced their lives and if so in which ways, how much they thought MkV had influenced their sexual lives and what specific MkV teachings had influenced their sexual lives. Two of the authors (J.W. and G.M.) who conducted the data collection and analysis had also interviewed some of the participants during previous phases of the MkV study.

The study received research and ethics clearance from the Tanzanian Medical Research Coordinating Committee and London School of Hygiene and Tropical Medicine. Information sheets were read and written informed consent obtained prior to interviews. Spousal consent was sought when requested by the participants (all nine of the married women). Permission to record interviews was sought prior to commencing interviews.

Data analysis

Following each phase of data collection completed, tapes were transcribed verbatim. A sample of interviews (11/23) from all the three phases of data collection were translated from Swahili to English for the non-Swahili-speaking principal investigators. After each phase of data collection, preliminary analysis was conducted. Data were examined and coded in three stages. In the first stage, researchers summarized notes from the interviews and observations made during the interviews. These notes helped to form initial impressions from the interviews. In the second stage, interview transcripts and analytic notes were read by the two researchers separately and codes developed. In the third stage, data were coded using both a priori and grounded codes into broad and refined categories using NVIVO 7 software. The codes were, however, refined as the researchers examined the data repeatedly and discussed them between themselves. After all the coding was completed and charting done, searches were carried out. The searching involved thoroughly examining the individual codes for emerging patterns. These patterns were used to formulate theories. For example, one theory was ‘are young people who recalled most of the MkV intervention messages more likely to report applying the teachings in their lives?’, for example, having used contraception. In order to look for
evidence for this theory, ‘child codes’ relating to memories of the MkV intervention, reasons for premarital sex, contraception, number of partners and condom use were searched. These were then summarized into themes. Quotations illustrating the main findings were identified. In the presentation of the quotes, ‘I’ refers to the interviewer while ‘R’ is the respondent.

RESULTS

Socio-demographic characteristics

Most of the participants (11/12 females and 5/11 males) were from the Sukuma ethnic group. Many of the participants were peasant farmers (5/11 males and 10/12 females). The majority (8/11 males and 11/12 females) were Christians. The age range of the male participants was 24–29 years while that of the females was 24–30 years. The demographic profile of the participants was similar to that of the original trial cohort; however, a lower proportion of males belonged to the Sukuma ethnic group (Ross et al., 2007). Only one-third of the female participants (4/12) had been brought up by both parents. The other eight had lived with single mothers (5), single father (1) and/or other relatives (2).

The participants had each attended different trial primary schools. The majority had not gone on to post-primary school education (8/11 males and 11/12 females). Most cited family instability, lack of support from their parents and financial difficulties as factors which prevented them from pursuing further education. The majority of the participants were married (8/11 males and 9/12 females). One male and two females were in polygamous unions.

Memories and perspectives on key topics from the intervention

All the participants remembered the MkV intervention. The majority, however, needed some probing in order to refresh their memories about the specific intervention messages. For example, if a participant mentioned having received lessons on STIs, the interviewer probed about types of STIs and prevention methods. The specific ASRH lessons or messages recalled by most participants can be categorized into five main groups: avoiding HIV, avoiding other STIs, avoiding unplanned pregnancies (primarily recalled by females), life skills (primarily recalled by females) and condom use (primarily recalled by males). A married male participant talked about this in the following excerpt:

I: Can you remember the things you used to be taught in class?

R: Yeah, we used to be taught about matters on love and then STIs, HIV/AIDS, family planning . . . using protection [condoms] and we shouldn’t have many lovers.

I: And which thing interested you most??

R: . . . all of them . . . they were interesting to us in all aspects . . . you know, we’d be taught about how to protect oneself . . . so almost everything was advantageous.

Although most participants could talk about the specific intervention messages, most of them could not elaborate on the details of what they had learned under each message topic. Also, some specific intervention messages, such as abstinence and reduction of number of partners, were not mentioned outright by many participants.

The recall of messages varied by sex. Compared with young men (6/11), few women (3/12) spontaneously mentioned the ASRH intervention (MkV) when asked who or what had been influential in their sexual lives and decisions. Most of the young women seemed to have hazy memories of the intervention sessions and, for example, could not discuss the individual STIs that they had learnt about. On the other hand, almost all the male participants remembered what they had been taught about protecting themselves from STIs, such as syphilis, gonorrhoea and HIV and condom use.

More male participants (6/11) reported that they had been class peer educators (CPEs) when compared with females (3/11). The CPEs had received special training on ASRH and were supposed to help the intervention teachers during the ASRH lessons by acting out short dramas and being good role models. As might be expected, the former MkV CPEs tended to have more specific memories of the intervention sessions than the non-CPEs.

Most of the male participants, especially the former CPEs, talked about the short dramas
that were performed during MkV sessions, with the most-memorable dramas being the ones on STIs. They also recalled the names of some of the characters. A favourite character mentioned was of a boy who liked to have sex and in the end acquired an STI.

**Relevance and application of the ASRH intervention teachings in young people’s lives**

Most of the young people reported that they found it difficult to explain the influence of the intervention on their lives. The messages had not helped them to abstain, use protection or to reduce number of partners. Although they recalled some of the teachings such as those related to condom use and delaying sexual debut, they reported challenges to implementation such as cultural norms around masculinity and restrictions around female negotiation of sex, desire for children and economic constraints. There were differences according to gender in the reported application of the ASRH messages, with females finding it more difficult to apply many of the teachings.

**Message on delaying sexual debut**

More than half of the young women (7/12) mentioned reasons for not abstaining before marriage such as lack of economic support from their families and hence reliance on sexual partners for their needs, while men mentioned that they had been influenced by their peers to engage in sexual activity. Conversely, some mentioned that they found it difficult to abstain but could not explain why. A single young woman talked about her difficulty abstaining:

I: ... Why did you find it difficult to follow some of the lessons taught during MkV?

R: Of course, with regard to that one, I just don’t know what happens ... Because maybe they say you shouldn’t make love at all ... now I don’t know why it happens ... you’d just ignore it ... Of course, you’d know indeed that there is a danger, but you’d just do it without a condom ... now I don’t know what happens about that.

**Number of partners**

All the males and most of the females (10/12) reported having had more than one sexual partner. At the time of the interview, some of the participants (4/11 males, 6/12 females) reported currently having more than one sexual partner. Interestingly, the young woman who reported the highest number of lifetime partners (a total of 13) said that she had been a CPE. Although she remembered the teachings on abstinence and using condoms, similar to other young women, she reported that it was very difficult for her to implement these teachings in real life.

**Condom use**

All participants reported that condoms are available at local health facilities where they are distributed for free or sold at local shops in packets of 3 for 100–300 Tanzanian shillings ($0.08–$0.24).

All men reported having used condoms. A married man said:

I: ... Are there other things that you learned during MKV that you’ve made use of in real life?

R: There are some ... for instance, we used to be taught about practising safe sex, using protector [condoms] ... when we were young ... you see ... it is now helpful.

Although all the young men reported having used condoms at some point, they did not report using them consistently. For example, they said that they usually used condoms with women they did not trust and during a first sexual encounter with a new partner but not with women they trusted and/or planned to marry. A married male participant said:

I: Why did you use [condoms] with these people maybe and not the ones you got pregnant?

R: With these ones I used [condoms] because I didn’t trust them a lot.

While the female participants talked about the benefits of the life skills they had acquired through the MkV intervention (e.g. confidence in refusing men who approached them for sex), in practice they were not able to implement other teachings, such as those related to the use of condoms. Many women reported finding it difficult to use condoms, citing barriers to use such as trust for their partners, opportunistic sexual encounters and fear about the consequences of requesting their partner to use a condom. For the few women who reported ever having used a condom, they said that this was
rare and only happened if their partners decided to use one. Married females often felt unable to tell their spouse to use condoms, as this would be interpreted as their having been unfaithful. One married woman had the following views:

I: Mm. Have you ever used condoms?

P: I have never used condoms… [laughter] in fact I see that it is difficult for me, even to hint that to my husband is a problem.

I: What do you think of the training that you should use condoms?

P: I see that it is difficult in my life because when I go to use a condom, I feel as if he is no longer my husband

A few female participants (3/12) reported that they found it easier to sometimes encourage partners to use condoms not for disease prevention but with the explanation that they did not want to get pregnant as they were still in school. Premarital pregnancy was highly stigmatized and brought shame to a girl and her family. It was therefore a bigger threat than STIs, which were easier to conceal. For example, a single woman said:

It is me who told him we should use a condom… He asked why I wanted him to use a condom and I pretended I was tired of giving birth but in reality, I feared AIDS as well as pregnancy.

Some women found it difficult to explain why they were not able to use condoms consistently. While they mentioned one of their reasons for using condoms as being a desire to prevent pregnancy, their use was occasional or sometimes only with certain partners. A married woman who reported 13 partners but had only ever used a condom once with one of them, said:

I: Why did you tell him [one of the 13 sexual partners] that you should use a condom?

R: So as to protect myself against pregnancy.

I: And as for the other 12 partners, why didn’t you use condoms?

R: I just decided not to use them… I just preferred not use.

Some young people mentioned that they had used condoms in the past but they could not describe how to use them properly, raising doubts about whether they had actually used them. Paradoxically, some of the men and women who said that they had used condoms while married were also the ones who mentioned having had fertility problems and having had unprotected sex with multiple partners in order to try to conceive.

**Contraception**

Both young men and women reported that they had sometimes tried to prevent premarital pregnancy. The women (5/12) who reported attempting to prevent pregnancy used methods such as condoms, intra-uterine device, the oral contraceptive pill and the calendar method. The main motivations for pregnancy prevention were fear of consequences such as being sent away from school or their home. These women reported the direct benefit of the MkV intervention on their sexual decision-making in relation to pregnancy prevention. For example, a married female participant attributed her decision to discretely use contraceptive pills to prevent pregnancy while she was in primary school (aged 16) to the intervention teachings:

I: Mm. when you were with partner T did you ever get pregnant?

P: No, there is a time they [MkV intervention] warned us against getting pregnant… For the girls who like having sex, they showed us contraceptive pills… We were getting the pills from the hospital… I was using the pills.

Although some women would have liked to use pregnancy prevention methods, there seemed to be barriers. They reported adverse effects associated with family planning methods based on their own experiences or their perception of the risks based on what they heard from their peers. Two single women talked about their experiences:

R: When I first met partner 3, I did not want to use a condom. I tried using injectible contraception but stopped after only one round (3 months) because of bleeding continuously for one and a half months.

A second woman said:
R: I have tried using them [contraception] recently, but they have caused me problems... They caused me nausea and problems in the stomach... First I was given the pills, when I went back for a second time, I was given an injection.

Some young men reported that they started seeing the relevance of the teachings on pregnancy prevention after they completed school and got married. A few male participants (3/11) attributed their current use of condoms with their spouses as a family planning tool to the knowledge they had acquired during MkV sessions. A male participant (married) talked about how he had advised his wife to use contraception:

I have found this information [about contraception] very important... when we were studying about it in school, I was just hearing about those things and found them to be useless. But as I grew up and the danger increased... I then started seeing sense that this thing [contraception] is important... therefore I decided to discuss it with my wife and we agreed to adopt that method [Depo-Provera].

Predictably, the teachings on pregnancy prevention and condom use were useful for those still in school and those intending to prevent pregnancy but they seemed irrelevant to the young people who wanted to have a child. Young people talked frequently about the value of children in their communities and in their lives. Some participants (two females and one male) talked about their desire to have a child since they had been married for several years. They reported experimenting with multiple partners and having unprotected sex in the hope that they would be successful in having a child and hence, fulfil the cultural expectation for married people to have children. One married woman talked about her experience in the following:

Now what made me do that [have multiple partners] was that I took a very long time without having a child, from 2001 until 2006. When I went to the seminar... I said that, maybe let me try this one [having sex with a different man], maybe I will be lucky to get pregnant and get a baby... That is what tempted me very much.

**Sexually transmitted infections**

Some participants (five females and one male) reported that they had previously suffered from an STI and/or were still experiencing symptoms. These participants mentioned that although they had learnt about STIs during MkV sessions, they had not taken any steps to protect themselves. Of the four female participants who reported having had an STI, three also reported primary abstinence until marriage and one until two years after completing primary school (aged 18). It is apparent that their decision to delay sexual debut did not guarantee them better sexual health compared with those who reported that they became sexually active much earlier.

When they started engaging in sex, their partners were very much in control of many decisions in their relationships, leaving those who wished to apply the intervention messages with limited opportunity to do so. Moreover, the women seemed to adhere more to the cultural expectations around gender power relations than to the intervention messages, some of which questioned those gender norms.

**Intervention messages and the aspirations of young people**

One criticism of the MkV sessions from some male participants was that they were not linked closely enough to the long-term aspirations of the students. One participant pointed out that intervention messages such as warnings against getting STIs such as HIV or unplanned pregnancies, were not sufficient to make students think about how these outcomes would affect their long-term aspirations, such as having children, getting a good job or going further in education. Participants suggested the need for future ASRH interventions to emphasize that undesirable SRH outcomes at a young age could hinder achievement of their future goals and aspirations. This might encourage the young people to pay more attention to the ASRH intervention messages.

Although most young people reported that they had received the MkV intervention ASRH messages and had tried to implement some of these in their lives, it is important to note that some reported having also acquired additional information from other sources, such as antenatal and post-natal clinics, during HIV voluntary counselling and testing sessions, and through mass media. Some of the messages acquired from these sources were similar to those delivered in the MKV intervention, but with a greater emphasis on HIV/AIDS prevention and family planning.
DISCUSSION

This qualitative study offers insights into the lives of young people several years after receiving an in-school ASRH intervention. Our findings suggest that the key MkV messages that were remembered centred around protection against HIV and other STIs, unplanned pregnancy, use of condoms and going to a health facility for specific services such as family planning. Although these key messages appear to have been retained by the majority, the details were not well remembered. However, details such as the risk of acquiring STIs, how to avoid risky situations, and specific pregnancy prevention methods, must be remembered well in order to be able to change behaviour.

Recall and relevance of intervention messages

The intervention messages were seen as having been relevant to young people, and some tried to apply them in their lives. The reported awareness of, and sometimes use of, condoms appeared to be the most important impact of the ASRH intervention for the young men and a few of the women. However, even though most young men reported having used a condom at some point during their sexual lives, it was clear that many had not used them consistently even within a particular relationship. The fact that some participants reported non-use of condoms with girls they ‘trusted’ or planned to marry was discouraging. For the few females who reported condom use, they said their use was very inconsistent and was mainly their partner’s decision. This finding is consistent with the low condom use reported in the country (TACAIDS, ZAC, OCGS, Macro International, 2008). The higher reporting of condom use by males compared with females in this qualitative study mirrors reports of condom use from the quantitative data in the same population (Doyle et al., 2010).

Although many young women reported that they found it difficult to put much of the MkV ASRH teachings into practice, there were a few who had selectively adhered to some of the messages, such as pregnancy prevention. Their motivation to use protection was mainly due to fear of being expelled from school and/or from their homes if they became pregnant. Other studies from rural Mwanza (Wight et al., 2006), and other parts of sub-Saharan Africa (Lesch and Kruger, 2005) have observed that young people were not expected to have sex while schooling and hence young women who did have sex tried to be very discrete and to prevent pregnancy.

In this study, condoms were viewed as a family planning measure that was relatively safe compared with other forms of contraception such as pills, which most respondents perceived to have adverse effects. It was also evident that the use of condoms was more easily justifiable to a partner as a means of pregnancy prevention as opposed to disease prevention. Interventions could capitalize on concerns about pregnancy to promote condom use and in doing so would also be providing protection against STIs.

Some young people were able to retain the key messages from the MkV in-school intervention but could not easily apply the teachings in their daily sexual encounters in order to protect their health. As observed by others (Cook and Bellis, 2001) having knowledge on health does not automatically result in a reduction in risk behaviours. Therefore, as much as having detailed knowledge is important, it was not sufficient for young people to change their behaviour. All the participants were sexually active and some had sexual relationships with individuals who were high risk, such as very mobile individuals and those who were able to provide substantial money or gifts in exchange for sex. The major challenge remains on how to change the social conditions of young people so that they are more supportive or in harmony with some of the intervention messages.

Gender–age power relations

The sexual behaviour of a young person’s partner with any other sexual partners is a very important determinant of the young person’s risk (Luke, 2003; Longfield et al., 2004) and may mitigate against the impact of ASRH interventions that only target the young people themselves. As noted in other studies (Plummer et al., 2006; MacPhail et al., 2009) women in this study usually did not feel confident enough to ask their partners to use condoms even if they suspected that they had other sexual partners, because that would be an explicit sign of their lack of trust. Alternatively their male partner might interpret a request for condom use as a sign that they had been unfaithful themselves. Young women therefore, relied on their male partners for most decision-making related to
their sexual lives. This is particularly an issue when the male partner was much older. Given the relative lack of agency by many young women within sexual relationships in much of SSA, SRH interventions that are targeted to young women, may have little impact if the messages do not also reach their male partners some of whom are older and out-of-school. Future interventions should focus on encouraging men to recognize the additional responsibility that comes with having greater power and to take this responsibility seriously for their sexual health.

Social norms

In rural Mwanza, some of the social norms were supportive of the intervention while others went against some of the fundamental teachings of the intervention. For example, there was agreement over the importance of avoiding early sexual debut; however, norms in terms of gender and age power relations went contrary to the message that young people should be assertive and change their behaviour in order to protect their health. As noted in this study and others (MacDonald, 1996; Wamoyi et al., 2010), cultural norms such as the great value placed on bearing children, traditional concepts of masculinity and norms of sexual exchange may be very powerful influences. The majority of our participants were already married and had children. Those without children made great efforts to have them, even sometimes having multiple sexual partnerships without using condoms.

These findings highlight limitations in psychological behaviour change theories such as the health belief model and theories of planned behaviour and self-efficacy (Rutter and Quine, 2002) when applied to a developing country setting. Such theories place primary emphasis on the power individuals have over their behaviours, with less focus on their social contexts. It is clear that behaviours considered as ‘risky’ may persist even if individuals have access to the necessary knowledge and resources (e.g. condoms). Research from Kenya (Luke, 2006) on the use of condoms suggests that women are active agents who often make decisions to embark on risky sex even when they have good knowledge and access to health services. In such contexts other factors such as lack of economic opportunities for women combined with unequal gender relations also influence their decisions. The relatively few women who mentioned that MKV sessions had influenced their lives suggest that structural and cultural norms were more salient for women.

Interventions that include a focus on the contextual factors of young people, including the norms that shape their behaviour may be particularly effective. Examples of such interventions might be those providing education about how to avoid infertility (e.g. by avoiding STIs) and those on parenting as a socialization mechanism and a pathway through which both safe and harmful norms can be transmitted across generations.

Link to young persons’ future aspirations

These findings demonstrate the need for ASRH programmes to make great efforts to connect and become relevant to the lives of young people by linking the intervention messages to their key values and aspirations. The MkV intervention messages tended to focus on immediate risks such as getting STIs or becoming or making someone pregnant. Less emphasis was made on spelling out how STIs could lead to subsequent infertility, or how getting pregnant while they were still very young could hamper their chances of achieving their long-term aspirations, such as to get a good job for themselves or to marry a man with a good job if they pursued further education. Hence, interventions with a focus on the impact of poor sexual health choices on future economic and social aspirations are likely to have much value.

Strengths and limitations

A key strength of this study was that it was conducted by two researchers who had been studying young people’s sexuality for over 10 years. They had interviewed many of the participants on two previous occasions. However, the study also had limitations. Some respondents had poor recall of details of the intervention messages, but it was often difficult to establish whether this was just due to their inability to retrospectively recall details after an interval of at least 5 years, or to a relative lack of importance or perceived relevance of the intervention sessions to their lives. Moreover, given that a higher proportion of the male participants were CPEs as compared with the females, it is difficult to know whether the apparent better recall
among males was due to their gender or because former CPEs had better recall. It is also possible that when participants’ attributed reported use of condoms or contraception to the MkV intervention that they had in reality primarily been influenced by other sources of information such as antenatal and post-natal clinics or mass media campaigns on this subject. Differences in reporting condom use for men and women could be due to reporting biases and the possibility that the male partners of the females were not exposed to interventions hence less likely to use condoms.

CONCLUSIONS

This study has demonstrated the importance of the social context in shaping the sexual histories and behaviours of young people. A major lesson from the MkV intervention (Ross et al., 2007; Doyle et al., 2010) and similar ASRH interventions elsewhere in SSA (Kinsman et al., 2001; Jewkes et al., 2008) are that more prominence should be given to interventions that attempt to directly influence wider socio-economic and cultural contexts. Existing individual-level interventions must be linked and integrated with wider programmes which address structural factors, such as improving the acceptability of contraception, reducing gender power imbalances and improving the quality of parenting and family structures in general. Future interventions should also be explicitly linked to young peoples’ future aspirations and capitalize on concerns about pregnancy, and should additionally target out-of-school youth and adults in the community.

ACKNOWLEDGEMENTS

This study would have not been possible without the support of various institutions and individuals. We appreciate the funding support from the UK Department for International Development (DFID) and Irish Aid, which made it possible to carry out the main MEMA kwa Vijana long-term follow-up survey and this qualitative study. Our gratitude also goes to the National Institute for Medical Research Mwanza Centre, in particular from the Director, John Changalucha, and from its Mwanza Interventions Trials Unit. In the preparation phases of this study we received valuable technical input and comments from Richard Hayes, Debby Watson-Jones, Helen Weiss and Shelley Lees of the London School of Hygiene & Tropical Medicine (LSHTM) and Pieter Remes of the Social and Public Health Sciences Unit of the UK Medical Research Council. We are most grateful for the support and detailed feedback we received throughout the study from our long-term colleagues in social science research, Mary Plummer of the LSHTM and Daniel Wight of the SPHSU. We also appreciate the administrative support we received from Frankie Liew of the LSHTM. Many thanks also to the study’s three transcribers and translator for their high-quality work. Last but not least, our sincere appreciation goes to our participants who agreed to take part in the interviews. Over the years they have continued to trust us with sensitive and insightful information which will continue to nourish our insight into the social circumstances and sexuality of young people in rural Mwanza, which we hope will lead to the development of better sexual health interventions.

FUNDING

This work was supported by the UK Department for International Development (DFID). The funders of the study had no role in the study design, data collection and analysis, decision to publish or preparation of the manuscript.

REFERENCES


