

Chapter 1

Barriers to behaviour change as a response to STD including HIV/AIDS: the East African experience

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Abstract

This chapter is based on a regional project being implemented in Uganda, Kenya, Tanzania and Ethiopia by the African Medical Research Foundation. The project, which targets young people aged 10-25 years, is a five-year initiative that started in 1995 and is currently in its final stages. The purpose is to improve young people's sexual and reproductive health behaviour through delayed start of sexual activity, reduced exposure to STD and HIV/AIDS and increased effective use of appropriate services. We present an analysis of the different strategies used in the four project sites, including provision of accurate information and recreational facilities, the trends in behaviour change that have been observed and the barriers to positive behaviour change including misconceptions regarding HIV/AIDS, cultural and religious values and lack of political will. Suggestions on alternative and effective measures for behaviour change among young people are also discussed.

There is documented evidence that more than 90 per cent of the people in the East African region are aware of the causes and means of transmission of HIV/AIDS (Nyamongo 1996; Amuyunzu 1997). A high percentage know the preventive measures, and many people have seen the destructive consequences of HIV/AIDS in their households and communities, yet this has not resulted in behaviour change. Caldwell, Orubuloye and Caldwell (1992: 1170) observe that:

Outside the elite the disease is little discussed. The victims refuse to put into words what has afflicted them and family members refuse to say, or apparently to admit to themselves, what is wrong with their relatives. There is an acceptance of the disease, even of death from it, which has surprised many foreigners.

It is also evident that many sexually transmitted infections occur among the youth, more so in the age group 16-29 years (World Bank 1989; *Africa Health* 1991). Promotion of condom use has been increased in all the East African region covered by the project, to enable those who cannot abstain from sex to have access to protective measures to combat the spread of HIV and other STDs. Despite these efforts, young people still run the risk of infections by engaging in unsafe premarital sexual activities. In recognition of this the African Medical Research Foundation (AMREF) designed a five-year regional initiative in 1995, to test the effectiveness of

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various strategies for adolescent sexual and reproductive health in diverse socio-economic conditions in Ethiopia, Kenya, Uganda and Tanzania.

The project has been designed to use a health promotion approach to realize its goal of improved and maintained health status of adolescents in the region. The main problems are inaccurate information and inaccessibility of health care services for young people's sexual and reproductive health. With the recognition that various determinants underlie health problems in adolescents, the project has various activities, including research, testing of model interventions, networking, advocacy and documentation of experiences for both internal and external consumption.

Background to the project

In order to design effective interventions, the project sites were carefully selected to reflect the different socio-economic conditions in the region. Thus, the project is implemented in different settings in the four countries (see Table 1).

Table 1
Project sites

Country	Project site	Targeted youth
Ethiopia	Region 14 in Addis Ababa	In and out of school
Tanzania	Lake Region of Mwanza	In school
Uganda	Kabale	In school
Kenya	Nyamira	Out of school

A baseline survey was conducted in all the project sites in 1995-1996, during the first eight months of the project; it involved youth, parents, community leaders and community members. The methods used for data collection were focus-group discussions, key informant interviews, and questionnaires. The results indicated a variety of factors that influence young people's sexual behaviour, such as their need to experiment, peer influence, lack of guidance and poor role modelling by adults. The adult respondents said, during discussions, that the age at first sexual intercourse has steadily become lower over time. The mean ages recorded from the questionnaire with the young people were: Ethiopia, 16.5 years for boys and 17.4 for girls; Tanzania, 15.5 years for boys and girls in primary schools, 16.2 years for boys and 18 years for girls in secondary schools; Kenya, 15.5 years for both boys and girls; Uganda, 14 years for both boys and girls.

Results from the qualitative studies tended to place the age at first intercourse between 12 and 14 years (AMREF internal publications¹). Parents expressed the view that children as young as 8-10 years are sexually active in situations such as slum areas and broken homes. A high percentage of single youth in the four project sites reported having ever had sexual intercourse: Ethiopia 20 per cent (n=1517), Uganda 52.2 per cent (n=1031), Tanzania 73 per cent (n=954) and

¹ Publications referred to are Ethiopia baseline report, Nyamira baseline report, Mwanza baseline report, Uganda baseline report and a summary of the baseline research findings for Uganda, Tanzania, Kenya and Ethiopia.

Kenya 85.3 per cent (n=613)². Around 85 per cent of the Ugandan respondents knew of someone with AIDS in their communities, and 30 per cent of them had a household member with AIDS.

In order to understand young people's sexual needs, the study also established reasons for early sexual activity and factors that contributed to it. The most predominantly cited reasons in Kenya are presented in Table 2.

Table 2
Perceptions of young people's reasons for engaging in sexual intercourse, Nyamira, Kenya

Reason	First sexual intercourse (%)	Subsequent intercourse (%)
Natural feeling	36.7	28.8
Express love	36.5	9.4
Condition set by partner	0.4	9.7
Peer pressure	9.9	13.3
Force	2.7	7.6
Adult influence	2.2	3.4
Expectation of gifts	2.5	2.4
Other	-	11.2

In Ethiopia, where the respondents were mainly school students, the most common cited reasons for early sexual debut were pleasure and personal fulfilment. Engagement in sexual activity was seen by some young people and adults as an event that must occur at puberty. An Ethiopian adult respondent noted that it is natural for the young to want to experiment at this time. Adolescence is referred to in Tanzania as the 'foolish age' which legitimizes the young people's 'deviant' behaviour.

It was also recognized that some young people have chosen to abstain from sexual activity, and the study established the most common reasons cited for doing so. Table 3 records responses from Kenya; they also reflect the reasons given by youth in the other three countries, with minor differences in percentages.

Table 3
Young people's reasons for abstaining from sexual activity, Nyamira, Kenya^a

Reason	Males % (n=25)	Females % (n=34)	Both % (n=59)
Not good to have sex	37.5	47.1	42.6
It is sinful	37.5	41.2	41.0
Fear of pregnancy	-	32.4	32.4
Do not feel like	45.8	23.5	31.1
Fear of STDs/AIDS	33.2	23.5	27.9
Fear of parents	4.2	11.8	8.2

^aSome respondents gave multiple reasons

² In Kenya, the study focused on school dropouts, with 40 per cent aged 16-20 years old and 60 per cent aged 21-25 years.

Fear of sexually transmitted diseases including AIDS ranked low despite the young people's high level of knowledge in all the countries (over 90%) and despite their having experienced the consequences of HIV and AIDS in their own households and communities. In other words, to tell young people that AIDS is a deadly disease is unlikely to bring about behaviour change.

Major factors influencing young people's behaviour were discussed and these included lack of access to accurate sexual and reproductive health information; idleness and lack of recreational facilities; poor management of reproductive health problems including pregnancies, post-abortion care and STDs; and poverty, which has led to school dropouts and the rampant unemployment in the region.

The strategies designed by the project team are aimed at addressing these issues in collaboration with the beneficiaries and other people involved. The main activities carried out are intended to facilitate positive sexual behaviour change among the young people.

Project strategies

Equipping young people with accurate information

The need for this arose from the recognition that the young tend to rely on each other for sexual information. Cultural inhibitions put a distance between them and their parents, teachers and religious leaders with whom they have regular contact. The following were the main sources of information on sex cited by the youth in Mwanza; responses from the other project sites are similar with minor differences.

Table 4
Sources of information for youth, Mwanza, Tanzania (%)

	Primary school		Secondary school	
	Boys (n=276)	Girls (n=308)	Boys (n=206)	Girls (n=102)
Girl friend	36.0	40.0	55.0	36.0
Boy friend	42.0	24.0	56.0	27.0
Relative	4.7	4.2	17.0	11.0
Teacher	3.3	1.9	9.2	8.8
Parent	3.6	3.6	12.0	7.8

Five ways of communication have therefore been initiated in the project sites.

1. Development and distribution of IEC materials by the youth themselves, e.g. the *Eye* in Nyamira. Youth centres established in each project site are used for distributing sexual and reproductive health materials, showing educative films and providing a forum for discussions.
2. Provision of life planning skills training for peer educators in Kenya, Uganda and Tanzania. Support systems have been established for their dissemination of accurate information to their peers. The peer educators have been well received by the young people and have enjoyed community support. In Tanzania, 120 student peer educators have been trained and 120 teachers have also received training for providing

- supervisory and technical support. In Kenya, 72 young people have also been trained.
3. Development of teaching curricula for schools in Tanzania in collaboration with the Ministry of Education for classes V-VII. Over 154 teachers have been trained in the national AIDS curriculum.
 4. Use of radio programs to pass on positive sexual and reproductive health information. This replaces the current messages transmitted to the young through radio, print media and television that tend to encourage sexual activity and the good feeling it gives to young people. Publicity of Adolescent Sexual and Reproductive Health (ASRH) project activities has also contributed immensely in making communities sensitive to the needs of the young people and has hence increased support for the projects.
 5. Question boxes in all the youth centres and in strategic positions within the schools. The young people are encouraged to put their questions in the boxes with only their age indicated. The project team, in consultation with local health personnel, respond to these questions and disseminate the responses to the youth. The questions also form a basis for the health learning materials produced by the young people. The questions focus predominantly on adolescent development and boy-girl relationships.

Provision of recreational facilities

The east African region is unlike developed countries where recreational facilities are found in most towns. Most rural areas in East Africa are bereft of facilities such as social halls, playing fields and even paved roads. Young people not at school are vulnerable to early sexual activities because they are idle most of the time. In Tanzania, a young person reported that 'in the villages unemployment contributes, you find a boy does not have a job, he is not in school and is idle the whole day so his thoughts concentrate on sexual intercourse'. The Kenyan project has highlighted the fact that most projects focus on school students, and even parents have the same bias. The regional project has therefore facilitated the establishment of youth centres, one each in Tanzania and Ethiopia, and two in Kenya. In Uganda, owing to its focus on school students, health clubs have been established and they provide forums for young people to discuss sexual issues and organize competitive sporting events.

The youth centres are equipped with sports materials for table tennis, balls and board games (Scrabble, Monopoly and jungle games). Efforts have been made to incorporate sex information in all youth centre activities: balls have sexual and reproductive health messages and the jungle game presents the dangers of premarital sex and promotes the virtues of abstinence and safe sex. Social workers and health personnel offer counselling and medical attention to youth in a confidential environment in the Ethiopian and Tanzanian youth centres.

Improved management of young people's sexual health needs

Access to services by young people is hampered by inaccessibility in distance and cost, stigma, unfriendly health providers and lack of accurate knowledge on STDs and their proper management. One young man in Kenya, commenting on service providers, lamented that 'Those people are inhuman. You are in great pain hoping to get help but the abuses and shouts you receive in public are more painful than the pain that took you there'. About 40 per cent of the

Ugandan respondents who had suffered from STDs had not used any form of treatment mainly because of fear, cost and ignorance about the condition and its appropriate care. The project has also taken cognizance of the fact that the youth get health care from both formal and informal sources including traditional healers and drug vendors. The project has therefore facilitated four main intervention strategies: training of health providers in the provision of youth-friendly services; provision of accurate information on STDs and other reproductive health problems of youth; subsidized and confidential services at the youth centres (Tanzania); and promotion of abstinence as the best preventive measure against sexually transmitted infections. Use of condoms and fidelity are also promoted for the youth that cannot abstain.

Improved socio-economic status of the youth

Poverty is a major problem especially among the out-of-school youth who often feel demoralized and are therefore inclined to early sexual exploits. It also limits the ability of the young to get health care and to bargain for safe sex. In Tanzania, the cost of treatment for urethral discharge is approximately Tsh 1,250.00 (US\$ 2.00) which most young people cannot afford. To improve the socio-economic status of the young people not at school, income-generating groups have been organized. There are 41 youth groups in Nyamira, involved in activities including carpentry, mosquito net making, tailoring, knitting, aquaculture and horticulture. The project provides the basic equipment, technical knowledge and supervision. The groups are responsible for all management. In Ethiopia, a group of young men have been trained in wood and metal work. The project plans to give them small amounts of loan money to enable them to set up their own businesses.

Observed trends in behaviour change

Behaviour change has been assessed mainly through observation and informal interviews and conversations with the youth and community members. The young people are more willing to discuss sexual and reproductive issues with the project staff. This is a major step considering the cultural inhibitions on such discussions within the region. On discussing sexual issues in Kenya, Nyamwaya (1996: 8) has reported 'matters related to sexual behaviour are rarely discussed in public in Kenya because sex is a taboo subject for most Kenyan cultures'. The number of young people frequenting the youth centres has increased in all the project areas. Because the centres offer group and individual counselling services, and provide reading and viewing materials of relevance to sexual health, the young people's knowledge of adolescent development and consequences of early premarital sex has improved. The influence on sexual behaviour, especially abstinence from sexual activity, is yet to be assessed.

Peer educators, who have been trained in life planning skills, have received support from other young people and the community; they are role models to the others. They have taken their responsibilities seriously and there have been few cases of dropping out among the school students. There has however been a higher dropout rate among the out-of-school youth due to movement out of the study area in search of jobs and vocational training. Courses covered in the life planning skill training include values, decision making, adolescent development, building self-esteem, and information on STDs including HIV and AIDS.

The project team has noted an increase in the use of condoms in Tanzania: this may not be due only to the ASRH project but also to other people such as 'salama' condom distributors. It

has also been encouraging that at the end of discussions boys ask for condoms. In Uganda, condom use was reported by 55.6 per cent (n=45) at the 1995 baseline and 86.5 per cent (n=37) during the mid-term survey that was conducted in 1997. Although this increase could be related to the higher age of the respondents and increased sexual activity, it signifies a notable increase in condom use. Consistency in the use of condoms has however not been established.

Barriers to positive behaviour change

Several factors hinder change in behaviour among the youth in the region, including their unplanned sexual intercourse. Young people often do not think and plan about having sex because the social environment does not allow them to do so. In many cases, boys meet girls on their way to the market or river, or to fetch firewood, and if they agree, they have sexual intercourse. Therefore, carrying condoms or being prepared to say 'no' may not always determine whether or not the young people will have sex .

Misconceptions regarding HIV/AIDS and other STDs act as hindrances to behaviour change. The variability and undefined nature of AIDS and its characteristic wasting puts it in a very special category within the East African classification. Caldwell *et al.* (1992: 1175) observe that 'The fear that AIDS might be caused by witchcraft or sorcery may easily lead people in affected areas not merely to ignore and fail to discuss it but to censor it in their own minds'. There is also a widespread belief that people who have lost weight cannot be infectious (Nyamwaya 1996: 8) and among men that plump women are safe (Schoepf 1988). Misconceptions regarding the effect of sex information on the young also act as barriers. Many adults in the region are wary of their children being given sex education: for instance, it cannot be provided in Kenyan schools because of fear that it will encourage young people to be promiscuous. Although sex education is given and examined in the Uganda school system, parents and religious leaders resist strongly one of its components that discusses condom use. Misconceptions regarding condoms are also significant. Some young people in the region who do not use condoms label them as ineffective, liable to burst, laced with HIV and either too big or too small for African youths.

Stigma is attached to AIDS in the four countries. In many communities, the condition is largely seen as self-inflicted through promiscuity and unprotected sexual encounters. Caldwell *et al.* (1992) noted:

Much of AIDS-affected Africa is now convinced that there is a relationship between AIDS and illicit sex... Announcing AIDS victims in the family is like shouting their illicit sexuality to the world. Traditional and imported religions have combined to render this improper and indecent (Caldwell *et al.* 1992: 1173).

Thus, people do not try to find out their HIV status. Those who know they are HIV-positive tend to be secretive in order not to be shunned by their friends, families and communities. Although people are being encouraged to go for HIV testing in the region, there are no demonstrable benefits in doing so. Many young people ask 'why should I test? How will it benefit me to know whether I am positive or negative?'. The value of testing therefore is lost in a system without appropriate counselling and HIV management. Caldwell *et al.* (1992) wrote:

People feel, with some degree of logic, that there is no point in knowing that one has AIDS and no charity in telling others that they have it. Governments are tempted to adopt similar attitudes because economic difficulties have led to the health care systems being strained to breaking

point without the potentially immense burden that AIDS could place on them (Caldwell *et al.* 1992: 1171).

Young people react to HIV/AIDS with comments such as 'AIDS came for people', 'I am not a tree to be used for furniture' and 'everybody will die anyway'; these are reasons they give for continuing sexual activity in an environment that has tended to depict sex negatively in terms of disease, death and unwanted pregnancy. Young people also tend to see themselves as indestructible. The adult population has not helped. Adults tend to seek teenagers for sex because they believe they are not infected. The idea that AIDS patients are thin and sickly has tended to expose many of the young to HIV infection from carriers who look healthy.

The high illiteracy levels hinder information-sharing on HIV and other STDs. Although to reach communities that have low literacy levels several means of communication have been devised, such as discussion and use of visual aids, it is expensive to do this on a large scale. Further, the illiterate are denied access to more detailed and elaborate information in print and electronic media, media that are increasingly used by the government and other development agencies.

The issue of gender imbalance has a bearing on behaviour change. It has been noted in the project sites that girls do not participate as much as boys in project activities. This is a concern especially in Ethiopia where girls' attendance is very low. Another factor is the inability of girls for cultural reasons to bargain for safe sex. In Tanzania, boys were asked what they would think of a girl who carried a condom and many said that they would consider her 'a prostitute' or 'to have a serious disease such as AIDS'. The girls' lack of involvement aggravates their vulnerability because women are generally blamed for the spread of HIV and other STDs. This emanates from their inferior position in their communities and from the initial focus of HIV transmission, which was on prostitutes and long-distance truck drivers. Caldwell *et al.* (1992: 1173) report: 'Often women who have been infected by their husbands may be blamed, and may be thrown out in a moralistic way by their husbands if they are unfortunate enough to develop the symptoms first'. In Kenya, it has been reported that young women in the age group 15-24 are two to three times as likely to be infected as males in the same age group (Okeyo *et al.* 1998: 12).

Some cultural and religious beliefs are often detrimental. In some situations, HIV/AIDS-related symptoms are given cultural relevance far removed from biomedicine, as curses, taboos and breaking of societal norms. These beliefs hinder certain groups from using proper preventive and management procedures, thus predisposing individuals to HIV and hampering the containment of the virus. The notion of death as uncontrollable by humans also complicates behaviour change. Bascom (1969: 72) when reporting on destiny has written 'the day of one's death can never be postponed but other aspects can be modified by human acts and by superhuman beings and forces'. Therefore people consider HIV infection and death from AIDS as preordained by their God; this has currency in both traditional and new religions. Certain religious doctrines and practices forbid the use of preventive measures: for instance, Catholics and Muslims oppose the promotion of condoms in Kenya.

Poverty is a barrier at the national, community and individual levels. Lack of resources for health services and for dissemination of appropriate health learning materials prevents sensitization regarding HIV and other STDs. Poor communication networks (radio, television and roads) hinder the transfer of information to the young people and other members of the community, who need it most.

Lack of supportive political will is another barrier to young people's effective behaviour change. Some countries in East Africa find it hard to admit the magnitude and impact of HIV/AIDS because they need to maintain a particular international image; therefore, they do not accord it the seriousness it requires. For instance, promotion of tourism may inhibit public recognition of the problem. Kenya has only recently (1997) admitted that AIDS is a major public health problem. This reluctance may be linked to the inability of the governments to provide management to HIV and AIDS-infected and affected people. Fredland (1988: 3) observes 'it is not politically useful for a government to acknowledge the presence of a disease for which it can provide no useful treatment, much less a cure'. Further measures such as censorship of film videos and setting age limits for admission into guesthouses and hotels, which could reduce the risk of transmission of STDs, requires the support of policy makers. Such policies may exist but are not enforced. There is also a clear need for young people to be given sexual health information both formally and informally, but support at the policy level is often lacking.

Abuse of alcohol and other drugs by the young is becoming a serious problem in the region. Substance abuse inhibits the ability of youth to make rational decisions. The need to provide for their addictions inclines them to crime and sexual activities that expose them to the risk of sexually transmitted infections. Injecting drugs directly exposes them to infection.

Discussion: where do we go from here?

It is no longer arguable that the developmental characteristics of young people, risk-taking, sense of invulnerability and lack of cognitive maturity to understand consequences of actions, expose them to HIV infection and pose a great danger of spreading the problem further (Forsberg *et al.* 1998). The fact that most young people's sexual encounters are usually unplanned makes the promotion of behaviour change even more complex. Most of the young people are therefore what Butler *et al.* (1996) refer to as 'pre-contemplators', that is, individuals who lack awareness that they or others may be at risk; those who are aware that their behaviour is considered risky but deny that risk; and those who have made a conscious decision not to engage in the recommended safe-sex behaviour. It is evident in the project areas that the young people are in these categories and they have developed ways of responding to the apparent risk they face.

It has also been recognized that whatever risks young people face, they rarely do a cost-benefit analysis before having sexual intercourse (Nyamongo 1996). Given that most young people are at a stage when they experience many biological, emotional and social changes, efforts aimed at reducing STD including HIV have to take this development into account. The complications posed by the different cultures and religious doctrines also need to be addressed. Despite these facts, there are possible means of effective behaviour change in populations such as those in the East African region.

There is need to design programs that are responsive to each person's situation and the choice made regarding sexual expression. The main goal should be the promotion of the safest method for practising a chosen sexual activity (Butler *et al.* 1996). Religious barriers that oppose the promotion of condoms in the region assume that all the young people are capable of abstaining; project findings indicate the contrary. It is therefore counteractive to spend time and resources promoting abstinence to young people who have chosen to have sex. The efforts should be directed to making their decisions safe by promoting use of condoms or fidelity, whichever will be received more favourably.

Condom use needs to be promoted in such a manner as to make it more attractive. Rumours and myths regarding the effectiveness of condoms have been barriers to their adoption within the East African region. These should not be ignored; they should be used in the design of marketing strategies. The strategies used in social marketing which have been effective in bringing about change in behaviour should be applied in the promotion of condoms. Hovell *et al.* (1994) propose multiple interventions with emphasis on bringing changes in the social networks. They propose a strategy similar to the one used in the campaigns to eliminate tobacco use in the USA (Nyamongo 1996:13). This needs to be tested and documented.

Young people consider themselves indestructible and a behaviour change strategy has to take this into account. Some studies have found that having role models who are not infected has proved ineffective in bringing about behaviour change. The proposed approach is for programs to make use of young people who have STDs and who are HIV-positive to educate the rest. Seeing one of their own suffering may remove the illusion that they are 'safe'. Forsberg *et al.* (1998) have targeted young people who are already infected with HIV to control further spread of the disease and this can be replicated in other settings. Young people tend to have multiple sexual partners and controlling the spread will minimize the rate of infection, but for this to be effective, there has to be a culture that promotes voluntary HIV testing accompanied by counselling services. However, experience in the project indicates that young people have developed a way of dealing with the evidence of the destruction caused by AIDS: seeing other people dying of AIDS has created a sense of hopelessness that has made the young people devise coping measures. Other ways of approaching the HIV/AIDS problem may be required in such circumstances. Some religious leaders have proposed a more positive approach to sex without labelling it as sinful, fatal and painful (*Church Leaders' Workshop Report* 1999). Positively discussing sexual matters and the virtues of procreation and minimizing the negative aspects including infection with HIV is a proposed alternative. This needs to be tried and documented.

Adults play a major role in the spread of HIV infection among young people: the notion that the young are free of infection causes adults to introduce the virus into this age group. The dangers of the adults' behaviour have also to be addressed. Men tend to pursue girls in school uniform and entice them with money and gifts for sex. Testing of HIV status should also be promoted so that young people demand such information from prospective sexual partners. Currently, many religious groups require an HIV test result before performing weddings; this move needs both political and community support. The government has a big role to play in ensuring appropriate counselling and HIV/AIDS management structures to make the testing worthwhile. Girls need to be empowered to say 'no' when they perceive an unsafe prospective sexual encounter. This can only be done through their active participation in intervention activities and their understanding of their sexual rights. The community, which reinforces the inferior position of women, should also be made aware that this is a factor in the spread of HIV and other STDs.

A final observation relates to behaviour change as a subject for academic research. Sexual matters are complex and change cannot be achieved within a short period. From the East African experience a minimum of 10 years is required to demonstrate behaviour change. Monitoring and evaluation indicators have to be designed from the beginning and documented. Many projects are unable to demonstrate the impact of HIV/AIDS because they are designed as responses to crises rather than as models that are replicable in other settings.

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