Introduction

For some time, and especially since the 1994 International Conference on Population and Development, there has been a growing pressure to involve men in issues related to reproductive health. Men have been encouraged to take more responsibility for the consequences of their sexual behaviour, to take equal responsibility with their partners for family planning, and to share domestic and child-rearing responsibilities. This is not an easy task, particularly in developing countries, because of the prevailing and deeply entrenched beliefs that make it seem natural to expect men and women to behave differently in the sexual as in so many other domains. Thus it is not surprising that a recent study in Brazil has found that often women assume that contraception is their sole responsibility while their partners take only a marginal role (Carvalho et al., 2001).

The challenge becomes greater when the problem is to promote sexual and reproductive health among young people in low-income groups. It has been argued that the particular characteristics of this segment of the population – an inclination to break rules and take risks - make it especially vulnerable to unplanned pregnancies and sexually transmitted infections (STIs) (Mota, 1998). Some authors have characterised these sexual risks of the young Brazilian population as lack of information to deal with the sexuality, omnipotence and a feeling of invulnerability, barriers and prejudice, difficulties in making decisions, lack of identity, conflict between the reason and feeling, the necessity of group affirmation, and the difficulties of dealing with waiting times and desires (Santos Jr, 1999). Differences in gender norms and their association with adolescent sexuality also play an important role. In Brazil, as in many other societies, sexual activity and discussion of sexual issues are more acceptable among young males than females (Nascimento and Romera, 1999).
The level of sexual activity among adolescents in Brazil, as in many other developing countries, is high and on the increase, in a setting where information, guidance or services to support their healthy development are usually inadequate or almost non existent. Consequently, increased sexual activity among adolescents has not been followed by the adoption of safer sexual practices to avoid AIDS/STIs and unwanted pregnancies (Juarez and Castro, 1999; CDC, 1991; Ferraz et al., 1992; Morris, 1988, Santos et al., 2000).

In Brazil, the national fertility level has declined since the mid-sixties (Fernandez and Carvalho, 1986) while a widespread upward trend in childbearing among adolescents has been observed, as in many other countries in the world. This has occurred despite the fact that Brazilian teenage women of today are more likely than their mothers to live in urban areas, to have a higher education level, greater access to information, and more opportunities to participate in the labour force. Apparently, the socio-cultural changes which have caused fertility to decline in some age groups have had the reverse effect among adolescents (Fernandes, 1995). An increasing rate of adolescent pregnancies is especially observed in rural areas and in the poorest regions of the country, such as the North and Northeast regions (Camarano, 1988).

Regarding AIDS, the country has presented a stable prevalence rate of 0.6 percent since the year 2000. However, around 30 thousand new cases on average are identified each year, particularly among women and old people. With respect to other curable STIs, such as gonorrhoea, Chlamydia and trichomoniasis, about 12.5 million Brazilians presented with at least one of these infections in 1999 (WHO, 1999).

Up to the present, very little has been known about the sexual and reproductive health knowledge, attitudes and behaviour of young males. More worrying is the non-existence of programmes or guidance on how to reduce sexual and reproductive health risks, in particular unwanted pregnancies and prevention of STIs/AIDS. Considering the importance of this topic and the need for practical advice on how to improve sexual health, a project was implemented Design and Assessment of a Peer-led Programme for the Promotion of Condom Use among Adolescent Males in Recife, Brazil. The aim of this project was to reduce unwanted pregnancies, STIs and AIDS in low-income areas in Brazil. Reasons for starting to use condoms were investigated as well as reasons for refusing to do so. An intervention was designed that incorporates the key elements of AIDS and reproductive health programmes in the world that appear to be successful. This project was led by the Centre for Population Studies (CPS) at the London School of Hygiene and Tropical Medicine, in collaboration with two Brazilian counterparts, Fundação Joaquim Nabuco and BEMFAM.
The Intervention

This section describes briefly what the intervention was about, so that it is understood what type of data are used and to put in context the findings presented. As the Gente Joven programme of the Mexican family planning association (MEXFAM) has been internationally recognised as one of the most successful in reaching adolescents in less developed countries (Aguilar, 1991), the intervention has adopted key aspects of this approach peer-led, an outreach strategy, and participatory techniques. However, modifications were incorporated to allow for the different cultural setting, and to take into account findings from CPS research on adolescent reproductive health in Recife (Marques, 1995). Further elements of success factors from the literature on AIDS and adolescents sexual health were incorporated. An innovative component of the design of this intervention (not followed by Gente Joven) was the incorporation of marketing methods. Help with the design of appropriate methods was obtained from motivational experts and their contribution has been very significant.

The use of mass media was part of the publicity campaign, but since the programme was being rigorously evaluated, careful consideration had to be taken in each promotional activity so as not to contaminate the control area whilst targeting the intervention site. The advice of MMS was sought at each stage of the intervention. Another key partner was the Local Community Radio. They promoted the adolescent programme, advertised meetings, lectures and other activities. For example, the community radio’s adolescents’ programme was scheduled to celebrate ‘Valentine’s Lovers’ day (dia dos namorados) with a contest of love phrases to the girlfriend or boyfriend. The intervention team suggested a modification to the contest to incorporate the concept of safer sex and improved reproductive health. So the contest was changed to include phrase about ‘love is good and more so if it is safe and responsible’ (namorar é bom mas com cuidado e responsabilidade). In addition, on that radio programme, the intervention team gave information on STIs and unwanted pregnancies and the scheme was promoted.

The Recife intervention Proteger was a peer-led outreach programme directed to boys aged between 13 and 19 years, with or without sexual experience, regardless of their sexual orientation. The programme was aimed at improving sexual and reproductive health by encouraging young men to adopt safer sexual behaviour and by providing knowledge on HIV/AIDS, STIs and family planning. Proteger offered a menu of activities, from participatory talks and mini-courses, to street festivals and activities at bars and dancing places. One of the most important components was the peer

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1 The main advisors have been MMS Comunicações (a well known publicity company recommended by TV-REDE GLOBO who elaborate their advertisements) and TV REDE GLOBO.
educators, young males, called promoters. They were recruited from the target community of the intervention and trained to pass on information about sexual and reproductive issues, and to promote and distribute condoms among sexually active adolescents. Leaders and followers were continuously contacted and recruited. This snowballing procedure continued throughout the 15 months’ duration of the programme. Promoters of the intervention and other young people involved in the intervention were volunteers; no payment was made to them. The training programme was directed towards instilling or intensifying that commitment.

Adolescents with STIs or with other medical, mental or reproductive health problems were referred to specialised health facilities. The support of local voluntary organisations working with young people was also sought. Owing to the high dropout rate of adolescents from schools (full dropout or non-continuous schooling) and the widespread unemployment among them, it was essential to use a community approach for this group.

**Data and Methodology**

Since a very strong evaluative component was incorporated in the project, data were collected in a control and an intervention area. Questionnaire surveys before and after the intervention were used to measure its impact, together with focus group discussion and in-depth interviews.

The baseline survey was carried out among 1438 males aged between 13 and 19 years in the intervention and control areas. The questionnaire was designed to collect relevant data such as socio-demographic status, childhood family of orientation, sexual knowledge, beliefs, values and attitudes relevant to the use of condoms and other contraceptives. The follow up survey was carried out immediately after the intervention. A total of 1446 adolescents were interviewed. About half of this total was interviewed in both surveys. The follow up data are not available yet.

Qualitative data were collected to guide the intervention. A total of three focus groups were conducted at different times in the intervention site, and 19 in-depth interviews, 11 of them conducted in the intervention site and eight of them in the control area at initiation of the intervention. Young leader promoters of the programme were interviewed a few months after the initiation of the programme. Another round of in-depth interviews with the same young men took place at the end of the intervention. The cohort approach adopted for the in-depth interviews allowed us to guide the intervention, find out more about what attracts boys, and what appears to makes a difference. Further, the cohort approach was expected to help us to observe the process of

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2 These young males were trained and supervised by a team of psychologists.
change in reproductive health, if any that might have occurred among the adolescents targeted by the intervention.

Although the qualitative sample is rather small and is not representative of all the adolescents in the area, in this study we are assuming that the responses in this sub-group, the active participants, would typify the range of views of the young population targeted by the programme.

Both the intervention and control sites are low-income areas and have similar socio-economic characteristics. The intervention site consisted of three districts (bairros) of Recife, Northeast Brazil, while the control area was a district of Olinda, a city adjacent to Recife.

This paper explores the qualitative data from the first round of the in-depth interviews and focus groups. The central aim is to highlight the attitudes and perceptions that prevent safe sex and the process that may occur to adopt a new behaviour free of reproductive health risks.

The preliminary findings presented here are organised in the following way: first, the current patterns of adolescent sexual behaviour, second, the reasons for refusal of safe sex, and third, an exploratory analysis of the processes through which adolescent males go from an unsafe to a new behaviour of safer sex in the study area.

**Current Patterns of Adolescent Sexual Behaviour**

The baseline survey revealed that roughly 40 percent of the respondents of control and intervention sites were aged between 13 and 15 years, with around 30 percent in each of the 16 to 17 and 18 to 19 age ranges. Almost all the adolescents were attending school and did not have any formal job at the time of the survey. The vast majority was of ‘mixed’ ethnic background, Catholic and single.

The results indicate that, in general, adolescents in both areas (intervention and control) start their sexual life between 13 and 15 years. The partner at first intercourse is very often a friend and it takes place in the home, or locations near their homes or schools. A large percentage did not use any protection in the first intercourse (around 68.6 percent in both areas). Among those who declared to have used protection, the condom was the most cited method (98.4 percent). The basic results of the survey are in line with the qualitative data regarding some important variables, such as age at commencing sexual life and the relationship with the first sexual partner.

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3 Selection of areas was based on their similarity in terms of their socio-economic condition, household density, participant observation, consultation with experts in the field and comparison of census data. On the whole one observes that the intervention and control areas are similar (and with similar internal variation) with respect to their socio-economic characteristics and background variables.
The literature has suggested that usually adolescents do not consistently use protection in their first intercourse (Stone and Ingham, 2002; Viegas-Pereira, 2000; CEBRAP, 1999). This pattern has been observed in other societies, and young people frequently explain that it has to do with the unexpectedness of intercourse. When analysing the qualitative data, this pattern is also observed in our sample of young males. In the qualitative study, some adolescents in the intervention site reported having used a condom in the first sexual experience. Among those who used protection in the first intercourse, half of them did so because they had been asked to by their partners. This finding is of interest, since studies in other countries have shown that women are socialised to be submissive and not to discuss sex (Kim et al., 2001; Campos, 1998). The traditional values that place women in a more passive role may be, to some extent, changing in Recife. As stated by one of the young males interviewed:

I used a condom. My partner had one and she asked me to use it (17 years adolescent, intervention area).

We agree with Stone and Ingham (2002) that changes are possibly being brought about by the ability of adolescents to communicate and negotiate wishes which are crucial to the effective use of protection.

Different reasons were mentioned for the use of protection in the first intercourse; for example, when protected sex was decided by the adolescent male and when the partner requested it. Young males were more concerned with prevention of STIs/AIDS while their female counterparts were more concerned with preventing an unwanted pregnancy. This is evident in the following statements:

I use a condom because I am always afraid of catching an STI (18 years adolescent, intervention area).

She asked me to use a condom, because she did not want to be pregnant (16 years adolescent, intervention area).

Despite the apparent gender difference in motivation, some male adolescents seemed to be worried about their partners:

I used a condom because I did not want to catch an STI. Also, because I did not want to make her pregnant (15 years adolescent, intervention area).

A recent study in Belo Horizonte has shown similar results, i.e., girls are more concerned with avoiding pregnancy and boys with avoiding STI/AIDS (Viegas-Pereira, 2000). According to this author
the difference in gender roles which is established at home leads the young women to perceive the risk of acquiring HIV infection to a lesser extent than their male counterparts.

On the whole, almost all of the adolescents who participated in our in-depth interviews and focus groups stressed the importance of having protected sex and the need to know about contraceptive and protective methods (with special emphasis on the condom); for example,

It is very important to use a condom (18 years adolescent, intervention area).

My message to other adolescents is: have a condom available and use it, regardless of the situation (18 years adolescent, intervention area).

So why do only a small proportion of them use condoms regularly? Very often, adolescent males only have protected sex with partners other than their girlfriends. Maybe this inconsistent behaviour reflects the view that ‘although risk perception increases protective behaviour, presumption of the partner’s behaviour influences this perception, placing men and women in a vulnerable situation’ (Vieira et al., 2000). Next we explored the reasons that lead adolescents to adopt a behaviour which is not systematically protective.

**Reasons for Refusal of Safer Sexual Practices**

Many justifications for the practice of unprotected sex have been pointed out in the literature, including lack of knowledge about how to use a condom, the unavailability of condoms at the time of the intercourse, lack of trust in the efficacy of the condom, etc. Here, we have grouped the reasons mentioned by the adolescents into four broad categories:

a) lack of information;

b) unexpectedness of the event;

c) those related to the use of the condom: reduction of pleasure, based on personal experience or that of a friend; the condom makes the contact between penis/vagina difficult, lack of trust, etc; and

d) those related to risk perception: previous knowledge of the partner’s sexual history and the irresponsibility of some adolescents regarding the risk of pregnancy in their partners.

Lack of information is an important reason for unprotected sex as pointed out by some promoters during one of the focus groups. When asked why their friends did not use a condom, young males responded

The people are much uninformed (16 years promoter, focus group two).
Many people use the condom only to prevent a pregnancy. They do not know that it should also be used to prevent STIs (17 years promoter, focus group two).

A girl came to me and told me she was in a sexual relationship with someone. She said that her partner was using a condom, but only to avoid pregnancy. She would like to know whether she could catch an STI, if her partner did not use a condom (15 years promoter, focus group two).

The second category of reasons is mentioned in relation to the first sexual encounter as well as for other relationships. Most of the adolescents were not expecting to have sex at that particular moment, as illustrated by some participants of the group discussion,

I did not use any protection. I did not know what was going to happen (18 years adolescent, focus group one).

I did not use anything. I had not planned to have intercourse at that time (17 years adolescent, focus group one).

Sometimes, the reason is a combination of factors such as condom availability and risk perception.

I did not use protection, because I did not have anything available. In addition, it was my first and her first experience (18 years adolescent, focus group one).

Regarding the reasons related specifically to the use of condoms, what seems to be behind the discourse is that the condom represents a barrier that can have a negative influence on sexual performance.

Almost all the adolescents asserted that ‘Condom spoils the pleasure’, regardless of their experience in using one or not.

The disadvantage of using a condom is that it bothers a lot (18 years adolescent, intervention area).

I have heard that we do not have pleasure when we have sex using a condom. So, I prefer not to use it (18 years adolescent, control area).

Having sex using a condom is the same as eating a sweet with the wrapper (17 years adolescent, intervention area).

Though it is true that, usually, education messages focus only on the idea of the condom as a ‘barrier’ to prevent STIs/AIDS and unplanned pregnancies, condoms as ‘a barrier to sexual performance’ should also be taken into account. However, a careful distinction has to be made between lack of knowledge on how to put on a condom correctly, and actual barriers to sexual performance. In the
data collected, both those who have actually used condoms as well as those who have never used one put forward these views. This negative perception of condoms and the myths about their use are evidence of the inadequate information that young males have. In this environment of lack of knowledge, it is not surprising that rumours and misinformation prevail across almost all the studied population.

In addition to the idea of a condom as a ‘barrier to sexual pleasure’, very often their efficacy is questioned. The statements below suggest that, even when using a condom, particularly to prevent pregnancies, a risk is still perceived,

- Condoms are not a hundred percent safe. Some of them split (17 years adolescent, control area).
- Condoms are not completely reliable. I have heard a story in which the girl became pregnant because a condom split (15 years adolescent, intervention area).

It has been pointed out that, sometimes, the inefficacy of the condom is associated with a lack of correct knowledge of its use (Santos Jr., 1999). In our study, suspicions regarding efficacy are observed even among those possessing good knowledge on how to use a condom. In fact, most of the adolescents described – at least in theory - how to use one. These anxieties of the inefficacy of the condom are a reflection of the negative perception of young males toward condoms. Thus, it is not surprising that a large proportion, even though they were able to describe how to use a condom, reported more negative aspects of their use. Information is passed on from friends and spread out in the community.

Some adolescents interviewed attributed condom failure to the source of supply. Many believe that certain brands of condoms sold at pharmacies are reliable while those distributed by Health Centres are not; for example,

- There are some brands that split. I only use “Jontex” (15 years adolescent, intervention area).
- Condoms can split. This happens, mainly if you use an old one, kept for a long time (17 years adolescent, intervention area).

The final category of reasons mentioned seems very important in determining the sexual behaviour of adolescents in our sample. The lack of systematic use of a condom is also associated, to some extent, to the perception of their knowledge about the previous sexual history of the girl. This perception, sometimes accurate in reality and other times not, is sufficient reason for the young men to know if they are at risk and need protection or not. On the whole, risk is not perceived when
the partner uses an alternative method of contraceptive (other than condoms) or when they trust their partners are healthy. These findings, that safe sex is linked to trust in the partner, are similar to those found in other studies (Monteiro, 1999; Rieth, 1998). The practice of unprotected sex supports romantic values. It operates as if love was a protection against STIs.

The association between the pattern of irregular safe sex and the previous knowledge of the partner seems to be confirmed in the following extracts,

If I know the girl, if she is clean and seems to be hygienic with herself, there is no problem in having unprotected sex with her (18 years adolescent, intervention area).

I use a condom. We always did, from the first time, because we did not trust each other. I knew she had already had sex previously with other partners (18 years adolescent, intervention area). In this case, the partner was the girlfriend.

I used a condom because I did not know her very well. I was and I am always afraid to catch an STD (17 years adolescent, intervention area).

Perception of sexual history of the type of partner may lead to an inconsistent pattern of safer sex. This is the case of some of the adolescents who mentioned using protection in the first intercourse but not later. As stated in their own words,

I used a condom (first sex act). I demanded it. She was not a virgin and I did not want to take the risk. I did not use any protection (last sex act). Although it was my second experience, it was her first one (18 years adolescent, control area).

If I know the girl, I can choose to use a condom or not. However, if I do not know her, I give up having sex (18 years adolescent, control area).

In the majority of the in-depth interviews with the young males, there seems to be little association between risk of an unwanted pregnancy and use of condom. Avoiding pregnancy is not a strong reason to motivate young males to have regular protected sex. When questioned about the risks of an unplanned pregnancy, they stated that in such a case they were not worried as their family would support the child and take care of the new situation.

**Shifting from Unsafe to Safer Sexual Practices**

Demographic studies have pointed out that adoption of new reproductive behaviour may be explained by the diffusion theory. This theory has been used to explain fertility transition in Latin America.

Diffusion theory relies on social interaction as a key mechanism through which new behaviours, norms, and ideas are adopted, by means of acquiring information through social
networks or impersonal channels such as mass media. A social network is the complex of actors and relationships involving direct or indirect contact between individuals creating conditions leading to the adoption or rejection of a new idea, product or behaviour. The complexity of the social network with which an individual is involved varies with the level of development and the cultural context of the community he/she belongs to. The velocity of diffusion of new behaviours, norms and ideas is dependent on the complexity of the social network, the homogeneity of the group involved and the distance (social and physical) among social network members.

By analogy, adoption of new sexual behaviour may also be explained by diffusion theory.

In the context of the adoption of new sexual behaviour by low-income adolescents, diffusion theory stresses knowledge, attitudes and practices of safer sex by the target population. The essential idea of this perspective is that the behaviour spreads from innovators capable of influencing other individuals that adopted it as a result of innovator behaviour, irrespective of the social status of the adopters or of any cost-benefit calculation that would require the new behaviour. As Palloni (1998) stated ‘Adopting the new behaviour occurs as a result of re-evaluation of one’s choice in the light of other people’s behaviour, not as a strategic response or accommodation to a realignment of resources associated with one’s position in the social system.’ (author italics). How strong the innovator role is varies with the depth of information it has about the topic, its credibility and the force of its example – its social identity, as suggested by Montgomery (1996). Personal relations are more important for diffusion than impersonal contacts as suggested by Cleland (1985) ‘the experiences of close friends, neighbours and relatives appear to be of particular importance.’

However, since our interest here is to explore the specific effects that the intervention Proteger is having on the young boys, some factors that emerge in the process of change towards safe practices will be presented. Understanding the process of change and how interventions influence change is complex, but our qualitative data draw attention to some potentially key factors. The analyses here are focused on the information of young males who have participated more actively in the programme and who have had a longer exposure to the intervention. These young men represent the best example of how far the intervention can reach. Within the framework of ‘cultural diffusion,’ changes in behaviour are expected to be observed, initially, among the adolescents who have a leadership role in the programme, followed by the leaders’ closer friends, and, finally, among all the adolescents.

A pre-requisite for the development of the project was that there was a need/interest for it. That is to say, these particular young men would be concerned about their sexual and reproductive health. The feasibility study indicated that young males were concerned about getting AIDS, followed
by STIs, but avoidance of unwanted pregnancy was not a worry. Adolescents, in particular those from the control area where no programme was running, pointed out the importance and necessity of an education programme that could provide them with better information on health and sexual issues. According to them, this programme should have an intensive participation of peers, with ‘people who understand us, who have similar values, ideas, etc.’

An educational programme is welcome in our community. We can learn about AIDS/STIs, how to use a condom, etc (18 years adolescent, control area).

I think it is important to have talk about the subject, once a month, once a week, if possible every day (18 years adolescent, control area).

We should be provided with more information. It does not matter if women or men give the talk. However, for advising I prefer men, particularly if they are prepared on the subject and if they are not much older than me (17 years adolescent, control area).

From the qualitative data obtained from the young men, a tentative framework of how the intervention could influence behaviour is presented in Figure 1. We will not describe each of the boxes as they are self-explanatory and literature has recognised its importance. What we would like to highlight here are the new elements that arise from our step by step recording of the process of change as the intervention advanced.

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For example, a lot has been written about the benefits of peer-led programmes; young people frequently turn to their peers for information and advice, peer leaders offer the opportunity to participate in meaningful roles and to benefit from being a helper, similarities between the influence and recipient increase the persuasiveness of any message (Melbourne, 1995). However, we would like to highlight an element that has been detected in our interviews with the boys in the intervention beside those normally associated with peer-led programmes, which are well documented. A new interesting element is the attractiveness of ‘belonging’ to the programme. There was a desire similar to ‘belonging’ to a social club, where boys (and even girls) want to be part of it. We do not believe that this happened ‘only’ because they wanted to hear information about reproductive health - some might be curious about sexual issues - but there was a feeling that young people wanted to be part of the programme and enjoy its social benefits.

Those belonging to the programme increased their knowledge about sexuality and prevention of reproductive health risks. Increased knowledge seems to be a starting point of any...
change. As stated by Kim et al. (2001) 'increased knowledge and heightened approval lead people to recognise that new behaviours can meet a personal need, to decide to take action and, eventually, to adopt new practices'.

An interesting aspect observed was the improvement in terms of self-esteem. Literature has mentioned extensively the lack of self-esteem among young girls and the need for empowerment to prevent unwanted pregnancies and STIs/AIDS, while it has been considered that men are empowered with high self-esteem (Mota, 1998; Kim et al., 2001). The qualitative data suggest that one of the mechanisms by which the programme works to improve sexual and reproductive health is through increasing self-esteem and closing the gender gap. These attitudinal changes and their
self-perception lead to improved sexual practices. When asked about what their friends think about actively participating in Proteger, a common reply was,

They admire us (15 years promoter, in-depth interview).

The people look at us as though we are very important. We are important because we are growing. When we learn something new we go to our mates and tell them. My friends keep asking me: how is this, how is that… (16 years Promoter, in-depth interview)

Our classmates, after attending our talks, most of them come to us asking to be enrolled in the mini-courses (15 years Promoter, in-depth interview)

We are supportive, particularly when they need information about sexual health (17 years promoter, in-depth interview).

After giving a talk in my school, some classmates asked me to invite them to be promoters (15 years promoter, in-depth interview)

The increased knowledge along with the approval of the peers, family and community brought about by the intervention, seems to be a consensus, particularly among the promoters. As expressed by the boys with respect to their parents and other members from the community:

My father says it’s a good activity. My mother thinks that I am helping someone to protect (against STD/AIDS) (14 years promoter, in-depth interview)

My parents say ‘my son is a hero’ (joking) (16 years promoter, in-depth interview)

My father and my mother like the idea. They have encouraged me to be a promoter. (15 years promoter, in-depth interview).

My mother never said, but I am sure she is proud of me, because I can help other people. (14 years promoter, in-depth interview).

teachers also support us, even the head master... (15 years promoter, in-depth interview)

Some of testimonies of promoters regarding their new roles in the community are very enthusiastic. This seems to reinforce the idea that the intervention had an impact on their behaviour and self-esteem,

After becoming a promoter, I am more aware about STIs/AIDS. Previously, I was not well informed as I am now. In addition, I have got the respect of my friends (19 years promoter, in-depth interview).

Since I am better informed on sexual health issues, I am able to advise other adolescents (17 years promoter, in-depth interview).
Besides knowledge, my confidence has improved too. Now, I am no longer ashamed to talk to my colleagues about sexual issues (15 years promoter, in-depth).

Although knowledge, approval and self-esteem are fundamental steps to motivate the process of behaviour change, ready access to condoms at affordable prices is also fundamental. In fact, lack of availability and accessibility of condoms and contraceptives was mentioned as important barriers to the adoption of protected sex. Though this is not usually the main reason for risky behaviour among young people, difficulties in obtaining condoms/contraception are a deterrent to safer sexual practices. When required, young people on the programme had ready access to condoms and contraceptives.

**Concluding remarks**

This study has brought about some insights of the sexual knowledge, attitudes and behaviour of the young population studied, although at this stage our results can not be conclusive. Further analyses will be done when the follow up data and the second round qualitative data are available.

As discussed in this paper, changing behaviour depends on the motivation as well as on the conditions under which changes are attempted. Of course, it is a process that takes time, since it involves many cultural, social and psychological factors that we believe can be accelerated by adequate interventions.

What we observed is that participants in the qualitative study seem to be open to changes, recognise the importance of safer sex and, despite several constraints presented with regard to the use of the condom, it was possible to observe some signs of intent to change behaviour.

Although changing behaviour can be a general trend, long term campaigns and continuous interventions specially designed to reach adolescent must remain an ultimate goal. Adequate programmes can speed up and also support the process, providing conditions that ensure safer passages to adulthood for adolescents.

Gender inequities are constraints to changes in sexual behaviour and need to be addressed in campaigns, programmes, etc. There is almost a consensus in the literature that gender roles, along with other factors, contribute to risky sexual behaviour. Though the qualitative sample does not enable one to be conclusive, the testimony of the adolescents point to a closing of the gap between gender roles. They are apparently becoming more conscious that safer sexual behaviour to prevent unwanted pregnancy and to prevent STIs is a responsibility of both male and female. This argument is based on statements that appear in the section about “Current Patterns of Adolescent
Sexual Behaviour”, on many other statements not presented in this paper and also on statements that appeared during informal talking.

Finally, a new interesting finding is the influence the programme has had on self-esteem among boys. This reveals the potential of empowering men as well as women in order to attempt to close the gap created by gender inequity.

References


Paths to safer sexual practices amongst young men in low income groups


