Communication Strategies of Adolescent Sexual and Reproductive Health Programmes In Mozambique: Cultural Challenges

Lurdes da Balbina Vidigal Rodrigues da Silva*
Department of Linguistics and Literature, Faculty of Arts and Social Sciences, Eduardo Mondlane University, Mozambique

Abstract

Background: There are three primary adolescent sexual and reproductive health (SRH) challenges in Mozambique; namely: early marriage, early pregnancy and HIV/AIDS. In a bid to respond to these challenges, the Mozambican government created the Programa Geração Biz (PGB), in 1999. Based on peer education the PGB was intended to improve the SRH of young people otherwise described by the PGB as "the busy generation" as the programme’s name in Portuguese suggests. However, Mozambican youths continue to be exposed to risks related to their SRH. Being Mozambique a multicultural with around 23 ethnic groups, each with its own distinct language, all of which are Bantu in origin, this raises an important issue - if the continuing ASRH problems are also related to the programme’s communication strategies. It is necessary to ascertain the cultural challenges that hinder effective message delivery within the PGB. Studies recognise the role of culture in enhancing effective delivery of communication programmes. Concurrently, studies point to a lack of research analyzing cultural barriers for effective message delivery of health campaigns.

Objectives: (i) to examine cultural challenges identified by peer educators and adolescents for effective transmission of PGB main health messages; and (ii) to determine the implications of these impediments for the PGB.

Methods: non-participant observation, in-depth interviews and focus group discussions. Research questions were based on the McGuire Communication/Persuasion Model, and data analyzed thematically using Nvivo Pro11.

Results: (i) taboos surrounding sexuality, health terminologies, and parents’ attitudes towards early marriages are the cultural challenges identified; and (ii) these factors hinder effective delivery of program messages.

Conclusions: the cultural challenges contribute to PGB not attaining effective health communication messages. Taboos around sexuality have silenced open communication in this regard. Ideas of sexual abstinence, condom use and campaigns against early marriage stand in opposition to certain (static) orientations of Changana traditions.

Keywords: Cultural challenges, Sexual and reproductive health, Programa Geração Biz, McGuire's Communication/Persuasion Model

Introduction

Sexual and reproductive health needs of the young generation are a priority in Mozambique. In 1999, the Government of Mozambique created the Programa Geração Biz (PGB), an adolescent sexual and reproductive health (SRH) programme to improve adolescent sexual and reproductive health, including prevention of HIV and AIDS and other sexually transmitted infections (STIs). As well, the intention of the programme is to prevent unwanted pregnancies, avoidance of early marriages and pregnancies, promote the use of family planning as well as to train the adolescents in negotiation skills for safe sex with their partners [1]. At that time, the primary adolescent SRH issues were early marriages, early pregnancies and HIV/AIDS and other sexual transmitted infections [STIs]. For example, 56.6% of girls under 18 years old were married, 40% of girls were pregnant before they reach 17 years old and 13% of adolescents between the ages of 15 and 24 tested HIV positive [2].

The Programme combines a multi-sector approach with interventions in schools, communities and health centres - through the Adolescent-Friendly Health Services...
(SAA1)). Intervention programmes in schools fall under the jurisdiction of the Ministry of Education and Culture, and its primary aim is to train peer educators. In Portuguese, student educators are called *activistas*2 and it is their mandate to address all issues related to undesired pregnancies, under-age marriages, and STIs.

PGB peer educators share the age characteristic (youth) as a link between the educators and educated [3]. The peer educators provide information and advice [4] related to the main SRH issues to adolescents and youth.

After 18 years of PGB implementation, the programme has achieved substantial progress. An estimated total of 1.3 million people in Mozambique have been reached by PGB. It uses 6.957 peer educators to deliver SRH messages to adolescents [5]. Among others, the inclusion of out-of-school youth in the target population has made it a pioneering intervention. Nonetheless, various challenges have been encountered in terms of programme effectiveness. Although isolating and measuring the impact of one program is a difficult matter, one might in the case of such national, comprehensive long-term interventions expect overall improvement of SRH. Data indicates that many youths, representing 44% of the country’s population [6], continue to be exposed to risks related to their sexual and reproductive health (SRH). These include untimely marriage, early pregnancies, STIs, HIV and AIDS, unsafe abortions, childbirth outside health centres, etcetera [7]. For example, data indicate that 44% of Mozambican girls have experienced pregnancies before the age of 17. Also, 8.7% of HIV infected persons in Mozambique are youth between 15 and 19 years old. Of these, 6.2% are female and 2.5% are male [8]. Despite the implementation of the PGB countrywide and the progress achieved, these figures indicate that adolescent sexual and reproductive health (ASRH) problems remain.

Mozambique, with 27.128.530 inhabitants [9], has varied multi-cultural communities constituting approximately 24 ethno-cultural groups. Therefore, it can be asked if the continuing adolescent sexual and reproductive health issues are also related to the programme’s communication strategies. It is necessary to examine if the programme communication strategies have taken into account the country’s complex cultural realities and diversities.

Studies indicate that culture plays an important role in the enhancement of effective communication strategies3 for public health campaigns. This is because the cultural characteristics or features of a group may lead to the group’s acceptance and adoption or rejection of health campaign messages. However, despite the recognition of culture in enhancing health communication strategies, there is little evidence supporting such a focus exists in health campaigns [10]. Therefore, further research should be carried out into communication strategies and cultural aspects of health campaigns [11].

Thus, this study aims to:

(i) examine cultural challenges identified by peer educators and adolescents for effective message delivery in the PGB; and

(ii) reveal the implications of these challenges for the PGB.

My theoretical framework builds on an adapted version of four input factors of McGuire’s Communication/Persuasion Model, namely: source, message, channel, and receiver of messages [12]. McGuire’s communication/Persuasion model provides an effective way to analyse cultural challenges for effective health campaign communication strategies [13] (Figure 1).

### Methods

#### Study design

This study has adopted and employed a qualitative case study format [14]. The choice of this methodology was influenced by the fact that qualitative case study enables researchers to explore,

3 Communication strategy is a combination of methods, message content, and other elements of the communication process used through the right channels in order to reach a specific goal (Edgar & Volkman, 2012).

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![Diagram](image_url)  
**Figure 1.** The proposed McGuire’s Communication/Persuasion Model using its four input factors.
evaluate and understand programmes. Moreover, qualitative methods are useful in studies when little information exists about the phenomena, which is the case of the PGB. An interpretive or social constructivist approach supports the data collection and analyses in such cases [14].

**Study settings and period**

The study was conducted between December 2016 and July 2017 in the Mozambican province of Maputo.

Maputo province, located in the southern region of the country, has 26,058 km² and a population of 1,205,553 [15]. In Maputo province, the study was carried out in two schools: one school in the capital city of Maputo and one school in the district of Moamba. The main cultural group in the province is Changana and Changaná is the primary language spoken in Moamba.

Moamba is located around 75 km from Maputo city. It is approximately 4,628 km² in size and has about 57,568 inhabitants. Most of its population are adolescents and youth, accounting for approximately 40% of the populace [16]. Maputo was selected because it has the second highest prevalence of HIV and AIDS among people age 15-49 in the southern region of the country. It accounts for 20% of the national incidence of HIV and AIDS [7].

**The sample of the study**

Participants of this study were 33 individuals related to the PGB in Maputo province, namely: programme project officers, peer educators (sources of the messages in schools), and programme beneficiaries or adolescents in schools (receivers of the messages). In-depth interviews (IDIs) were conducted with three programme officers from the Provincial Departments of Health, Youth and Sports, and Education and Human Development in Maputo province. These interviews helped us to identify schools where PGB services were provided.

From these interviews, we obtained purposeful samples and chose participants from the four schools to be studied. A purposeful sample was used to select the study’s participants. A purposeful sample is a selection of information-rich cases for in-depth study [17]. This is valuable because it adds credibility to a sample when the potential purposeful sample is larger than one can handle.

Data was collected from one school in the capital city (Escola Secundária Francisco Manyanga) and at another school in the district nearest to the capital (Escola Secundária da Moamba). This was done in order to ensure rural-urban diversity.

Thus, 15 adolescents and 15 peer educators were selected based on the following criteria:

1. to be a peer educator or an adolescent of the PGB;
2. to have residence in Maputo province.

Peer educators were only selected if they had at least one year of fieldwork experience.

Adolescents were only selected if they had attended the programme for at least two weeks. Only adolescents aged between 12 and 17 years old were selected because they are considered a priority target group for the peer educators. All participants of this study are Changana.

Table 1 provides an overview of the main respondents’ characteristics and data collection methods.

**Data collection and analysis**

Data was collected in four ways: firstly, by interviewing the three programme officers using in-depth interviews. The interviews were conducted to better understand programme activities and its challenges. Programme officers were asked to: describe their activities, identify challenges related to PGB communication strategies; describe the communication strategies used to deliver health messages in the PGB; identify the cultural challenges for effective message delivery in the PGB; and indicate the schools and health centres to be studied and explain those choices.

Secondly, data was gathered through focus group discussions (FGDs) with peer educators and adolescents at the selected schools. Three FGDs were held with adolescents, as the receivers of the health messages, as well as three FGDs occurred with peer educators, as the sources of messages. From the FGDs with peer educators, 5 peer educators with more than two years of fieldwork experience were identified for in-depth interviews and non-participant observation. These FGDs lasted between 45 minutes and 1 hour and were tape recorded. FGDs provided initial insight about the cultural challenges PGB peer educators and adolescents encounter when delivering and receiving health messages.

Participants of these FGDs were asked questions on the following topics:

(i) cultural challenges peer educators and adolescents identify when delivering or receiving health messages; and

(ii) the implications of the identified cultural challenges for the PGB.

Thirdly, another five in-depth interviews were conducted with peer educators having field work experience of more than two years. In-depth interviews covered the same topics as those of the FGDs. Each in-depth interview lasted no more than 40 minutes and was tape recorded.

Fourth, non-participant observations were realised with five peer educators selected for in-depth interviews, providing health messages to adolescents. This allowed me to observe the peer

### Table 1: Participants characteristics and data collection methods

<table>
<thead>
<tr>
<th>Participants</th>
<th>Methods</th>
<th>Age</th>
<th>Gender M:F</th>
<th>Time in PGB</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer educators (sources)</td>
<td>FGDs/IDIs (n=3)/(n=5)</td>
<td>16-27</td>
<td>5:10</td>
<td>1-10 Years</td>
<td>15</td>
</tr>
<tr>
<td>Adolescents (receivers)</td>
<td>FGDs (n=3)</td>
<td>12-17</td>
<td>3:12</td>
<td>2 weeks - 4 Years</td>
<td>15</td>
</tr>
<tr>
<td>Project officers</td>
<td>IDIs (n=3)</td>
<td>25-35</td>
<td>2:1</td>
<td>1-3 Years</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>33</td>
</tr>
</tbody>
</table>


educators communication strategies in action. Importantly, it also allowed me to compare what peer educators and adolescents said during the focus group discussions and in-depth interviews, with what they actually did.

All interviews with the programme officers and peer educators were conducted in Portuguese.

Data collected centered around the main objectives presented earlier by posing questions related to the four input factors of the McGuire Communication/Persuasion Model as presented next:

**Sources of messages:** What cultural challenges do peer educators identify when delivering health messages to adolescents? How do they deal with these identified challenges? What are the implications of such challenges for the programme? Do peer educators take into account the sociocultural background of adolescents when delivering health messages?

**Messages:** What types of messages do peer educators deliver to adolescents? What language is used? What type of non-verbal communications is used? What features of effective communication are actually present?

**Channels:** What means or methods are used by peer educators to deliver health messages? Are they adequate to ascertain reality and context?

**Receivers:** What types of messages do they receive? What are the channels used by peer educators to deliver messages to them? What cultural challenges do adolescents identify when receiving health messages? What are the implications of the challenges faced by them?

Data were analysed thematically using NVivo Pro11. After the transcription of data, it translated the information from Portuguese to English and all participants were given fictitious names. Data analysis was performed through generating categories, coding text according to each category, annotating emerging themes and patterns as well as readjusting the categories.

**Ethics**

The Mozambican National Committee of Bioethics for Health as well as the Committee of Bioethics of the Faculty of Medicine and Maputo Central Hospital provided the necessary approval for this study, providing the reference numbers 45/CNBS/2016 and CIBS FM&HCM/016/2016. Written informed consent was obtained from all participants. Anonymity and confidentiality were safeguarded and interviews were conducted in locations requested by the respondents.

**Results**

**Cultural challenges hindering effective health message delivery in the PGB**

The cultural challenges impeding effective message delivery in the PGB in Maputo was obtained via the four input factors of the McGuire’s Communication/Persuasion Model – source, message, channel, and receiver of the message.

**Source of the messages**

All participants of this study agreed that PGB health messages are transmitted by peer educators, called “activistas” in Portuguese:

“The peer educators constitute the heart of the programme. Without peer educators, the programme does not work” (Project Officer Mateus, Maputo province, 2017).

**Messages transmitted**

All participants of this study revealed the messages shared by the PGB peer educators in Maputo province (Maputo city and Moamba district) are primarily preventive. They are about protection from HIV and AIDS, STIs, how to use a condom, negotiation skills with a partner, avoidance of early marriage and pregnancy. The following quotations from project coordinators, adolescents and peer educators illustrate this clearly:

“The main topics delivered by peer educators to adolescents are HIV and AIDS, Alcohol and other drugs, family planning, early marriages and pregnancies” (Project officer Joana, IDI, Maputo Province, 2016).

“They talk about sexuality; also they talk about preventing drug use, and contraception” (Adolescent Ceserilo, FGDs, Moamba district, Maputo Province).

“We talk about gender and sexuality; we talk about several conceptions methods and the prevention of sexual and transmitted infections” (Peer educator Emu, FGDs, Maputo city, 2016).

However, the predominant messages delivered to adolescents by the PGB peer educators in Maputo stand in opposition to many traditional practices of the Changana culture. Delaying first sexual intercourse; evading early marriage, avoiding early pregnancy, and condom use are in opposition to the cultural tradition which encourages all of these except the use of condoms. Adolescents explained it in this way:

“The challenge is to transmit what we learn to our fathers at home. This is because when I go to school and return home later and he asks me why I am late I explain that it is because of the speech given by the PGB and they talk about this and that is difficult because he did not have access to that information. He says: My son you go to school to study and they load you with these sexuality issues. It is difficulty” (Adolescent Edmázia, FGDs, Moamba district, Maputo Province, 2017).

Thus, most participants’ answers (both peer educators and adolescents) revealed taboos surrounding sexuality, condom use, forced or consented early marriages by parents, as well as health terminologies are the main cultural challenges obstructing the effectiveness of the PGB messages in both Maputo city and Moamba district. Next are presented each cultural challenges identified by the study’s participants in the PGB.

**The taboos surrounding sexuality**

Peer educators and adolescents identified taboos surrounding sexuality and sexual issues as a challenge. They said talking openly about sex and sexuality is not common or accepted in their communities. Sexuality and sexual issues are sensitive topics and are not to be openly discussed. In addition, sexuality issues are taught and talked about by adults and elders or individuals of the same gender:

“At home say that sexuality is only discussed by parents. Because you are a boy you talk to your daddy. No, it means that only the elders can talk about this issue. Even you with the father...
you cannot talk, until the right time comes (Adolescent Martina, FGDs, Moamba, Maputo province, 2016).

Peer educators and adolescents have indicated that although the PGB peer educator’s handbook says they should discuss sexual orientation with adolescents, in practice it can be difficult to do so. Peer educators refrain from discussing adolescent sexual orientations because people feel extremely uncomfortable talking about this topic. Adolescents explained in this way:

“We are afraid to talk about it [sexuality]. We feel shy when we listen about sexuality. Sometimes we do not feel comfortable... We feel like that because those are intimal things. It is shame to talk about it with someone” (Adolescent Shaina, FGDs, Maputo city, 2017).

Even the peer educators’ responses reveal why they face challenges when openly discussing sexual issues:

“We do not talk about sexuality with our parents. We do not have this habit. It is ‘svaila’, which means that it is something that cannot be spoken openly. This makes people criticise us” (Peer educator António, FGDs, Moamba, Maputo Province, 2017).

“Elder people sometimes do not want to listen to our messages because they say that we are too young to have such knowledge... It is taboo to talk about sexuality in these communities” (Peer educator Henriques, FGDs, Moamba district, Maputo Province, 2017).

Moreover, Moamba’s adolescents’ answers demonstrate that even when their parents talk to them about SRH issues, including sexual organs, they use metaphors. “Private parts” are given nicknames such as “bicho”, which means animal/beast, to refer to the male organ:

“Because at home we use “bicho” to refer to penis while at PGB and schools refers to it as penis, I got confused and without knowing what was correct and which direction to follow” (Adolescent Martina, FGDs, Maputo city, 2017).

Condom use

The participants of this study revealed that training in condom use is a challenge to traditional practices. This is due to religion, the traditional custom of having many children, the community beliefs about its harmful purposes, and the local belief in the unlimited powers of traditional healers.

Study participants in Maputo province point out the non-use of condoms is thought to be related to religious proclivities. Condom use is considered as a sin against God and Allah’s wish as they said men must procreate and fill the earth:

“Some adolescents say that they cannot use condom because of their religion. They say that they are protected by Jesus and as such, they do not need to use condom (Peer educator Ruth, FGDs, Maputo city, 2017).

Additionally, participants’ responses revealed that people abstain from condom use because of the allegedly negative impact of reducing birth rates. In those communities, a birth is considered a gift of life and the wealth of a man is measured by the number of his descendants:

“I am going to talk about the elders, our fathers and mothers. They say that condoms impede youth to have children. The trend of the Moamba’s community is to reproduce. Those who use condoms want to eat alone and do not want to have kids. That [condoms] kill children” (Peer educator António, Moamba district, Maputo Province, 2017).

Additionally, difficulties getting people to use condoms are related to rumours. There are stories that condoms are infected with HIV and AIDS. This situation leads to people refusing to listen to the health messages presented by peer educators. The following was revealed during several interviews:

“There are rumors that condom use brings sickness” (Peer educator António, FGD, Moamba district, 2017)

Furthermore, people refuse to use condoms because they believe if they become infected with any STIs, including the HIV and AIDS, the traditional healers have the power and knowledge to cure them:

“Other people say that they will take traditional medicines from the traditional healers that will protect or cure them from HIV and AIDS infections” (Peer educator Rosalinda, FGDs, Moamba district, Maputo Province, 2017).

These reported situations only lead to increasing numbers of HIV and AIDS infections in the country. This is because people do not have the culture or habit of using condoms. And when they use them, which is quite rare, they mainly use them with partners they do not trust:

“They use condom in occasional sexual intercourse and with partners they do not trust...” (Peer educator Maria, FGDs, Maputo city, 2017).

In addition, condom boxes installed in the schools generally remain untouched since adolescents rarely use them:

“The condom boxes remains full for months as adolescents do not use them” (Peer educator António, FGDs, Moamba district, Maputo Province, 2017).

Parents’ habits towards early marriages

Participants in Maputo city and Moamba district also identified parents as a cultural challenge due to the local practice of having girls marry young:

“Parents often tell their children to marry early: they do not send them to school” (Peer educator Edmázia, FGDs, Moamba district, Maputo Province, 2017).

In Maputo province, which is the Changana culture, parents force their female children to marry soon after their breasts appear:

“Here in Moamba and in the communities of Quensaque, Corrumane and Chinhanguanine, parents want cows. As soon as a girl is born they choose a wealthy man for her. And once the girl has breasts they force her to marry. The girl has no right to choose her own husband. She only has to accept her faith and destiny (Peer educator Henriques, FGDs, Moamba district, Maputo Province, 2017).

Once married, girls are expected to have children soon after.
Language and health terminologies

Language and health terminologies are another challenge identified by the participants of this study.

Answers given by peer educators in Maputo indicate they do not face language problems when delivering health messages. This is because they work directly with a medical doctor who provides them with health terminologies in the local language. However, they consider translation of health terminologies from Portuguese into the Changana language would greatly help them do their work:

“We do not have language difficulties when transmitting health messages to adolescents. We have the help of a Medical Doctor who gives us health terminologies in Changana. However, having a complete handbook with health terminologies in Changana, would improve our work” (Peer educator Henrique, Moamba, Maputo Province, 2017).

Peer educators’ and adolescents’ responses show PGB health messages are mostly delivered in Portuguese and sometimes and Changana, one of the local languages most spoken in Maputo province. Changana are used when adolescents have difficulty understanding Portuguese. However, in the presentation of a role play (theatre) about SRH topics, the language most spoken by the inhabitants of the Maputo province is used:

“We mostly use Portuguese for speech, and sometimes we use Changana for role play (theatre) on SRH issues” (Peer educator António, FGDs, Moamba, Maputo Province, 2017).

Peer educators in both provinces use a handbook called “Manual do Activista do PGB” – meaning the PGB peer educator’s handbook. It is their main educational tool:

“We have the peer educator handbook. I use the peer educator handbook to prepare myself. I take with me the handbook and some magazines to help me” (Peer educator Davity, FGDs, Maputo city, 2017).

Additionally, non-verbal communication is employed by peer educators to help them deliver health messages. This includes videos, CDs, flyers and posters:

“We use our materials such as flyers and posters to deliver SRH messages to adolescents. Most of our trainings and posters are provided by AMODEFA” (Peer educator Ron, FGDs, Maputo city, 2017).

Contrastingly, peer educators and my own observations pointed to the fact there is a lack of these non-verbal communications available in the district of Moamba:

“One of the biggest challenges for me is related to lack of work materials” (Peer educator Lionel, FGDs, Moamba district, Maputo Province, 2017).

However, some non-verbal communication such as replicas used to deliver health messages about the penis and vagina are considered offensive in the Changana culture. In this society, showing intimate parts is entirely offensive. In Changana, they use the expression “masingita” which means “shameful/lack of respect/insulting”:

“We sometimes cannot use some of our demonstrative materials such as vagina and penis because people consider them as insulting. They say “masingita” which means it is shameful, lack of respect and insulting in Changana. As a result, some people do not believe us, in our messages, because we openly discuss sexuality openly” (Peer educator António, FGDs, Moamba district, Maputo Province, 2017).

Moreover, PGB health messages are recounted to boys and girls at the same time, which is a cultural taboo:

“In the PGB we transmit health messages to boys and girls together” (Peer educator Isabela, IDI, Moamba district, Maputo Province, 2017).

When delivering health messages about HIV and AIDS and condom use, people may not believe the peer educators due to a lack of scientific evidence:

“Many adolescents and people ignore what we say. Some say that HIV and AIDS do not exist” (Peer educator Ruth, FGDs, Maputo city, 2017).

Channels Used

The participants’ answers and my own observations point to interpersonal communication as the preferred method used by peer educators to deliver PGB health messages in both provinces. Interpersonal communication includes one-on-one and small group communication. This is communication occurring on a personal level. Group messages are delivered in classrooms and open spaces of schools through:

“We use campaign face-to-face, speech, theatre, showbiz and debates to deliver adolescent sexual and reproductive health messages in the PGB” (Peer educator João, FGDs, Maputo city, 2017).

 Receivers of Messages

The receivers of PGB health messages in Maputo are adolescents and mostly from the Changana cultural. They are students attending the selected two schools in Maputo province. Their answers are reflected in other input factors previously presented.

Implications of cultural challenges for the Programa Geração Biz

Peer educators’ responses point to identified cultural challenges which interfere with effective delivery of key PGB messages. This is also because peer educators do not have a communication strategy to cope with the identified cultural challenges:

“Apart from the peer educators materials which include PGB peer educators handbook, some flyers and condoms, we do not have a specific document about the communication strategies based on the cultural challenges we face” (Peer educator Ron, FGDs, Maputo city, 2017).

“We do not have any specific document that addresses the cultural challenges identified” (Project officer Gabriel, IDI, Maputo Province, 2017).

The peer educators’ responses ignore these cultural aspects and keep on presenting information as they always have in the hope they will change the minds of a few who are open to their messages:
“We usually tell them the importance of using condom and other preventive measures” (Peer educator Ruth, FGDs, Maputo city, 2016).

Adolescents’ responses reveal they get confused with the various and often opposite orientations they receive from the PGB and from their communities, as explained by adolescent Martina.

Cultural challenges also lead some peer educators and adolescents to abandon the programme:

“Many peer educators in Moamba abandoned the programme because they saw that people are not listening to their health messages and advices. They quit the programme because they realised that they were working on something that does not produce any results” (Peer educator António, FGDs, Moamba district, Maputo Province, 2017).

Discussion

The objective of this study is to discuss the cultural challenges identified by peer educators and adolescents as getting in the way of effective transmission of PGB health messages in Maputo province. They include sexuality and sexual issues as taboo, lack of condom use, parents who force or allow their girls into early marriages, as well as language and health terminologies. The cultural challenges were obtained based on four input factors of McGuire’s Communication/Persuasion model: source, message, channel, and receiver. The sources of message delivery in the PGB are peer educators who deliver preventive health messages to adolescents (receivers of the messages) from the two schools in group or individually. The preventive health messages delivered by peer educators to adolescents are opposite to the messages transmitted by the adolescents’ communities. Each cultural challenge is discussed in detail below.

Taboos surrounding sexuality

Sexuality and sexual issues are the main cultural challenge identified within this study. All participants of this study pointed out that sex and sexual issues are not commonly spoken of or accepted in the Changana communities. These are considered sensitive topics and are not to be openly discussed.

Adults talk about sexuality with the young when they are about to marry, as is the case in the Changana culture. These customs are well explained in this study by an answer given by Martina, an adolescent from Moamba. She recounted that parents never spoke to their children about sexuality until the right time comes. The “right time” means that time or age when the adolescents are considered mature. Martina’s answer generally defines the taboos surrounding sexuality in Changana culture. Adolescents can only receive sex information from adults and elders [18] – but only when they are considered mature. In the Changana culture, this happens only after girls begin developing breasts or have their first menstruation. However, both boys and girls receive some form of sex education just prior to when they are about to marry.

In the Changana culture, adolescents who openly discuss sexuality are considered bad-mannered and disrespectful of their community’s customs. In these communities, traditionalists believe adolescents who acquire knowledge about SRH issues before what is considered the “right time” are more likely to follow a wrong path and have many sex partners. An interesting intervention could be to redefine the ‘right time’ in terms that are beneficial for family planning. This is one example of how a potentially harmful cultural practice can become advantageous after adjustment in dialogue with SRH educators and local opinion leaders.

When the Changanas do talk openly about sexuality – not a frequent occurrence – they often use figurative language to minimise taboos surrounding sexuality. For instance, when the Changana want to openly talk about sexuality – more precisely about the male sexual organ – they often use the Portuguese word “bicho”. “Bicho” means animal.

In Mozambique, “bicho” can be understood as something other than “animal” in relation to the sociocultural dimension between language and culture as suggested by Pennicook [19]. Pennicook explains what people do with language in a particular place is a product of their interpretation of the place and the language practices engaged in reinforcing the reading of that place.

Thus, in denotative terms “bicho” is used to designate an animal. The word “bicho” was borrowed from the Bantu word “nyoca” which means snake and a snake is a dangerous animal. Sometimes, by sematic extension, “bicho” is also used to designate an ugly person. Thus, the qualifiers “ugly person” and “dangerous” are then used to designate, in a connotative way, the penis – the male sexual organ.

The association between the penis and a snake are also related to the form of the penis which looks like a snake. Therefore, the male sexual organ, the penis, is compared to a snake because it is dangerous like a snake. And so, it is called “bicho” in Portuguese.

The penis, in this case, is designated “bicho” as a semantic analogy with something considered repulsive and dangerous. Because it is ugly and threatening, it is socially understood as something not to be displayed publicly. Consequently, boys are socialised with the idea the male sex organ is ugly; it is, “bicho”. Therefore, they grow up convinced they cannot show their “bicho” to anyone.

As well, girls are also socially taught to not play with “bicho” because it is ugly, dangerous and can harm them. “Bicho” can harm. In this context, girls are warned the penis can make them pregnant. Also, because the penis is a dangerous animal, people cannot customitself to it. Therefore, girls are advised not to get familiar with the penis because, as a dangerous animal, one day it may turn on against them. The “bicho” is a dangerous animal and can get pregnant.

In childhood and adolescence, education about sexual organs is communicated in an indirect way, using a figurative language. In the Changana culture, it is taboo to speak to children openly about sexuality or the sexual organs. This cultural way of viewing sexuality as taboo explains why most adolescents feel uncomfortable openly discussing sexuality. In these cultures, it is difficult for those who consider themselves as having “good-manners” to openly use the actual words vagina and penis. It is simply easier to use figurative language such as “bicho”.

To better understand this cultural challenge, I reiterate two cultural features shared by the Mozambican cultural groups: boys and girls learn one should not talk about sex openly, especially with...
adults, and sexual issues are taught by adults and elders [18]. The taboos surrounding sexuality challenge peer educators’ delivery of SRH messages in the PGB.

This is because the educators are young and as such, are considered to be lacking in this kind of knowledge. Also, the challenge arises from the fact that sexuality should be taught to adolescents when there are considered mature or when the “right time” comes. Right time means when adolescents are considered to be adults. This is when they are about to marry for the Changana’s.

The point of view defending sexuality should not be taught before the “right time” or when adolescents are considered mature is quite similar to the view about the harmful effects of early sex education given to youth. This way of looking at sexuality as a taboo is well documented in Bastien, Kajula, and Muwezi study [20].

Bastien, Kajula, and Muwezi maintain taboos around the discussion of sexuality are still common in developing countries and Sub-Saharan Africa due to their cultural norms [20]. In this regard, adopting sociocultural or cultural sensitivity approaches are key features of effective health communication strategies [21].

Therefore, when addressing culturally sensitive messages sex or sexuality openly, peer educators could apply audience segmentation. This is the simple process of dividing large and heterogeneous groups into smaller, more homogeneous subgroups [22]. For example, peer educators could use an established cultural feature shared by Mozambican cultural groups - boys and girls are educated separately [18]. When imparting “sensitive” SRH messages. Several studies demonstrate in most Mozambican rural communities, the family and community provide knowledge for youth integration into the community. This occurs daily and based on their gender. Interestingly, the information taught is similar and complementary [18]. Therefore, it would be useful for peer educators to implement this aspect when delivering PGB health messages.

In Changana communities, sexuality is essentially a taboo and only discussed by and with adults of the same sex. In Maputo, matrons, male adults and elders are responsible for providing SRH information to boys and girls, respectively, when the “right time” comes. Thus, due to these cultural barriers, it would be more effective if male peer educators communicate sexuality issues to male adolescents and female peer educators to female adolescents. Non-SRH topics such as negotiation skills and other practical information could be delivered in the same classroom/space to both male and female adolescents. This approach would place peer educators in a positive light. They would no longer be regarded with contempt. This would greatly help make the PGB communication strategy more effective.

Condom use is a barrier and its use would risk our freedom and salvation

Condom use is a serious cultural challenge identified within this study. Condom use is a challenge due to religion, belief in the curative power of traditional healers, the social custom of having many children, and the community belief in the harmful purposes of using prophylactics.

This research reveals how non-use of condoms is thought to be related to religious orientations. For both religions, condom use is a serious problem as they consider it is a sin against Allah and God as these deities orientate men to procreate and fill the earth.

For instance, peer educators state the use of condoms is a problem for both religions because it is believed they are related to promiscuity and immorality. Therefore, Muslim and Christian religious leaders are against prophylactic use. This association of condoms and promiscuity by both religions is similar to study results conducted by Pfeiffer and Murove and colleagues [23, 24].

Pfeiffer’s study points to the emerging and growing number of Pentecostal churches in Mozambique. These conservative churches from the West also promote non-use of condoms as they believe the use of them promotes prostitution, promiscuity and immorality [23]. Moreover, church pastors have angrily spoken out about HIV and AIDS campaigns carried out in the country. This is because they believe health campaign messages have contributed to the AIDS crisis, further spreading the disease. Typically these pastors are convinced condom use implicitly encourages more sexual partners since using condoms is considered safe [23].

These findings were corroborated by Murove and colleagues who also identified religious or spiritual practices – along with rites of passage, and marriage practices – as cultural practices posing risks to child protection. They further state understanding these practices are essential for the success of child protection responses in communities [24]. This is especially true in regards to child protection where focus falls upon harmful cultural practices.

The use of condoms is also refused because of the local belief traditional healers can cure all types of diseases. Responses from peer educators and adolescents confirm there is an overall belief that traditional healers can cure every kind of disease, including HIV and AIDS.

This vision of the “unlimited powers” of traditional healers is also reflected in many other studies, indicating this belief has not diminished. As a matter of fact, it may have increased or, at least, become more dangerous [25].

Mckay study discloses the weakness of the Mozambican health system has contributed to people seeking alternative treatment. He maintains the disarray of patients’ medical records has contributed to the lack of patient tracking within the Mozambican health system. This situation has excluded many patients from the national health system or they must stay for long hours in the hospital without being attended. As a result, many of these patients hesitate to rely on the clinical treatment provided by the health system. They then look for alternative treatment provided by traditional healers, spiritualists or religious leaders. This means that people often combine HIV treatment with healing practices and treatments from evangelical and other churches [25].

People also abstain from condom use because of alleged negative impact of lowering birth rates. Responses from peer educators revealed they were accused of encouraging young people not to have children which would have a negative impact on community life.
In most Mozambican cultures and in the culture of the study – Changana – in particular, life is considered a gift. As such, the idea of family planning, birth control or having fewer children is unacceptable for them.

Perceiving life as a gift in Mozambican cultures is also presented by Martinez study [26]. Martinez calls attention to the fact children are the truly considered to be the concrete warranty for family progress and stability. In the Makhwua and Changana cultures there is a belief that having many children is their wealth and those children will take care of them when they become elders. Moreover, there is great esteem for maternity in these cultures as shown in cultural feature shared by the local groups: girls are expected to have children after marriages [27]. The greatest aspiration of a woman is to stroll in the village or city carrying her man’s son/daughter on her back. This is a strong sign of motherhood. Giving birth in the Makhwua and Changana cultures means wealth, freedom from misery, certainty of life where before there was insecurity life [26]. A woman will always be respected in the family and village and will be called “mamana” by the Changana, which means mother. Family planning and birth control are not an issue in these communities and cultures.

Having many children is considered wealth or good fortune as earlier explained. In these communities birth is considered a gift of life and the wealth of a man is measured by the number of his descendants. However, this does not mean members of these communities do not know how to prevent pregnancies. Traditional knowledge to prevent pregnancy can be provided by traditional healers [27]. However, the traditional ways for preventing pregnancies used by traditional healers do not protect people from STIs, including HIV and AIDS.

Additionally, difficulties having people use condoms are related to rumours proclaiming HIV and AIDS are contained inside condoms. Rumors about condoms being infected with the HIV and AIDS virus as well as other diseases is in line with Pfeiffer’s study affirming the existence of messages undermining condom use has taken hold in many Mozambican communities [23]. This is generally due to clashes with traditional community norms and religion. Pfeiffer’s study reveals in many rural Mozambican communities, people refuse to use condoms because they believe condoms have harmful purposes. Studies recommend presenting scientific evidence – the evidential approach – to minimise cultural challenges [28].

In this instance, the scientific evidence/evidential approach would help peer educators support their arguments. They would be able to provide scientific evidence which would contribute to better message delivery to adolescents on SRH issues. This solution has already been suggested by Colvin [28]. Colvin states studies conducted in South Africa confirm the evidential approach has helped activists to better communicate preventive messages about HIV and AIDS.

**Marriages of Young Girls are considered natural: Parents’ consent**

Participants also identified parents’ consent to early marriages as a major cultural challenge. Adolescents and peer educators from Maputo province disclosed early marriages are decreasing in the country’s larger cities and their peripheries. However, in the country’s rural areas child marriage is still increasing. This is because in these communities, early marriages are considered customary practices.

In Changana culture, it is common practice for parents to marry their daughters at a very early age. This occurs when girls develop breasts or when they menstruate.

The results of this study, in relationship with premature marriages, are in line with the research by Murove, et al. [24]. According to Murove and colleagues, early marriages pose challenges to children’s rights and protection in many African countries. Countries advocating traditional practices include Swaziland, Kenya, Mozambique and Ghana.

The customs of Changan parents to force or merely allow their children to marry early is a clear violation of their children’s rights and thus, considered a harmful social practice. To protect children from exploitation and sexual abuse, the Universal Declaration of Human Rights (1948), the United Nations Convention on the Rights of the Child (1989), the African Charter on the Rights and Welfare of the Child (1990), the African Charter on Human and People’s Rights, as well as other international legislations were adopted by many countries, including Mozambique [29].

Mozambique has ratified most United Nation Conventions and African legislations and has adopted them to protect the rights of the children. The international and regional legislation on premature marriage adopted by Mozambique unequivocally defines marriage with a girl under the age of 18 years as a violation of her human rights.

Regrettably, the numbers of early marriages in Mozambique are not decreasing. Occupying 11th position in the world, it is one of the countries most affected by this phenomenon [30].

As an explanation for the increasing numbers of premature marriages in Mozambique, enforcement of social legislation is extremely difficult. Although there is legislation defining the minimum age to marry, there is no legal means to penalise those who do not comply with the law – such as Malawi and 23 other countries throughout Africa.

Also, accepting parents’ formal authorisation or consent for girls to marry at 16 years old should be banned. In its place, it should be established 18 years is the minimum age for marriage in the country.

At the same time, it is important to make Mozambicans parents and families aware it is their role to educate their children. In this regard, community training should be carried out in order to make parents understand it is their function to counsel and support their offspring until they are legally capable of taking their own decisions [29].

Thus, it is suggested that the implementation of community training will overcome these harmful cultural norms. Further, it is necessary to increase enforcement of existing policies and legislations as suggested by Raj, et al. study [31], and clearly criminalise premature marriage in the Mozambican Penal Code.

**Health Terminologies**

Health terminologies are another major challenge identified by participants of this study. The PGB peer educator’s handbook is written in Portuguese yet peer educators sometimes need to
translate health messages and terminologies into Changana, the predominant local language in Maputo Province. This happens when adolescents have difficulty understanding Portuguese. Further complicating the issue, there are no corresponding health terminologies to be found in the local languages so there is no frame of reference to be used by the peer educators.

Maputo peer educators reported they do not encounter language difficulties but they still do not use uniform health terminologies when communicating health programme messages. For example, all peer educators in Maputo city and Moamba recognise that having a glossary of health terminologies in the Changana language would enhance their communication strategies.

In this context, it is urgent and necessary to translate the PGB peer educator’s handbook into the local languages. Additionally, a glossary of the health terminologies contained in the PGB peer educator’s handbook should be made available in the local languages. This will greatly assist peer educators to relate the programme’s health messages as recommended [22].

Peer educators’ responses point out that the identified cultural challenges interfere with effective delivery of key PGB messages. These primary messages stand in direct opposition to several core orientations of the Changana cultures. Thus, early pregnancy and marriage, condom use, sexuality as taboo, parents who promote early marriage, as well as health terminology difficulties are still enormous challenges to effective PGB message delivery.

Moreover, the study shows peer educators do not have a strategy based on a cultural approach for delivering health messages to adolescents. Instead, they ignore the identified cultural challenges and continue to share PGB health messages as they have always done, hoping to reach some adolescents who are more open to their messages.

Peer educators’ responses concur with the studies revealing HIV and AIDS rates, early pregnancy and marriage remain high in the country [8]. For example, HIV rates among 15 to 49 years old has increased in almost all the nine Mozambican provinces – increasing from 11.5% in 2009 to 13.2% in 2015 [8].

Because PGB key messages stand in opposition to some community orientations, many adolescents get confused by the conflicting information they receive. This may well influence some adolescents to abandon the PGB programme’s main health messages.

Additionally, these challenges influence the ways in which adolescents perceive PGB peer educators – as bad-mannered and without (cultural) knowledge. This is also explained by Castro, Balcazar, & Cota study [32]. Their study suggests if sources of any health communication intervention lack cultural competence to gain trust and credibility from the receivers of the messages, they are more likely to be ignored by the receivers of the health messages.

Moreover, some peer educators also abandon the programme because they feel they are not reaching the target audience. They get frustrated with adolescents who cling to their cultural norms and do not listen to their health messages.

The identified cultural challenges discussed previously hinder effective PGB health message delivery. Current “static” orientation of these traditions leads to cultural misunderstanding while at the same time the PGB peer educators do not take into account these cultural factors. Successful bridging between community norms and PGB orientations should be considered, developed, and implemented. The intergenerational learning process, by which adults and elders adapt sexual norms and ritual messages to new circumstances, should be boosted. This can only be achieved with a community-based approach; by the development and implementation of a sociocultural/cultural-sensitive approach for the programme [21].

This study presents some limitations as it did not look into what motivates adolescents to stay in the program despite the cultural challenges identified. Future research could fill this gap.

Additionally, there is the need to study PGB’s influence on adolescents’ changing attitudes using the output factors of the McGuire Communication/Persuasion model.

We expect the results of this study will contribute to improving the communication strategies used in the PGB by addressing sociocultural approaches in other parts of the country.

Conclusions and recommendations

This study reveals taboos surrounding sexuality, condom use, parents’ consents for girls marry off at early ages, and language and health terminologies as the cultural challenges hindering the effective communication of PGB messages in Maputo province. This is largely due to the fact PGB’s main health messages are completely opposite to Changana traditions.

To reduce the cultural barriers and improve PGB efficiency and efficacy, it is recommended to apply a culturally sensitive approach in the development of partnership and cooperation between the PGB and local communities in order to change local norms concerning sexuality. Additionally, there is need to translate a PGB peer educator’s handbook with a glossary of health terminologies into the local language. This will preclude assorted and conflicting health terminologies being created by peer educators when discussing ASRH issues with young people. These proposals will strengthen the effectiveness of PGB. Peer educators must be further trained to gain a greater level of cultural awareness and to incorporate this into adolescent SRH education. This would allow them make a dear bridge between the adolescents’ cultural background and the intent of PGB.

Acknowledgements

I thank Desafio Programme; Eduardo Mondlane University, Mozambique; and the Flemish Interuniversity Council (VLIR) for supporting this research.

References


