

# **SOCIOCULTURAL RELEVANCE OF COMMUNICATION STRATEGIES OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES IN MOZAMBIQUE: A STUDY OF *PROGRAMA GERAÇÃO BIZ* ACTIVITIES IN NAMPULA PROVINCE**

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Adolescent sexual and reproductive health (ASRH) challenges in Mozambique include early marriages, early pregnancies and HIV/AIDS. In 1999 the *Programa Geração Biz* (PGB) was created to address youths' problems and improve their sexual and reproductive health (SRH). However, studies show Mozambican youths continue to be exposed to risks related to their SRH. Mozambique is a multi-cultural country but only 40% of Mozambicans speak Portuguese, the official language, while 93.5% of the population uses a Bantu language as their mother tongue. This raises an important issue – should PGB communication strategies (CS) take into account the country's complex cultural reality? Studies recognise the role of culture in enhancing effective delivery of communication programmes. Concurrently, studies point to a lack of research analyzing CS of health campaigns.

This paper's aims are: (i) to examine PGB communication strategies; (ii) identify cultural challenges to these strategies; and (iii) determine the implications of these impediments for the PGB.

Research methods included 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 revealed the following: (i) interpersonal methods are used to deliver preventive messages, with sociocultural approaches often ignored or not used to reduce cultural barriers; (ii) cultural challenges identified include initiation rites, taboos surrounding sexuality, language and health terminologies, and parents' attitudes towards early marriages; and (iii) these factors hinder effective delivery of programme messages.

The conclusion is that the CS used by PGB does not sufficiently take into account the Mozambican sociocultural context. 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 orientations of traditional initiations.

**KEY WORDS:** COMMUNICATION STRATEGIES, SEXUAL AND REPRODUCTIVE HEALTH, PROGRAMA GERAÇÃO BIZ, MCGUIRE'S COMMUNICATION/PERSUASION MODEL, CULTURAL CHALLENGES

## Background

This paper examines the communication strategies of the *Programa Geração Biz* (PGB), a Mozambican national adolescent sexual and reproductive health (ASRH) programme. The PGB was initiated in 1999 by the Mozambican Ministry of Health (MISAU)<sup>1</sup> in partnership with the Ministries of Education<sup>2</sup> and Youth and Sports<sup>3</sup> to address ASRH problems. The PGB's overall objective is to improve ASRH including a reduction in incidence of sexually transmitted infections (STIs) – including HIV and AIDS. Additionally, the PGB has worked towards reducing the numbers of early marriages and early pregnancies (Chandra-Mouli, et al., 2015; Pathfinder, 2013; Matsinhe, 2011; WHO, 2009).

Over a period of 18 years the PGB programme has achieved progress with its multiple approaches combining interventions in schools, communities and health centres. Peer educators are used to deliver health messages to adolescents in the PGB (Chandra-Mouli, et al., 2015). The PGB's peer educators share the age (youth) characteristic as a link between the educators and educated (Pathfinder, 2013). However, in spite of the PGB implementation countrywide, various challenges can still be identified in terms of the programme's effectiveness.

Young people make up a large share of the population, representing 44% (World Bank, 2011), and data indicates that many continue to be exposed to sexual and reproductive health risks (Chandra-Mouli, et al., 2015; Francisco, 2014; INE, 2012; INS, 2009). These include premature marriages, early pregnancies, STIs, childbirth outside health centres, among others (Chandra-Mouli, et al., 2015; Francisco, 2014; INE, 2012; INS, 2009). For instance, INE (2012) indicates that 48% of girls are married before they reach 18 years of age. The result is that Mozambique occupies the 11th position in the world ranking of countries most affected by this phenomenon (UNAIDS, 2014). Moreover, INS, INE, & ICF's (2017) study indicates 44% of Mozambican girls have experienced pregnancies before they reach 17 years of age. Also, 8.7% of HIV infected persons in Mozambique are youths between 15 and 19 years old. Of these, 6.2% are female and 2.5% are male (INS, INE, & ICF, 2017). These figures indicate that ASRH problems remain despite the implementation of the PGB countrywide.

With approximately 27,128,530 inhabitants (INE, 2017), Mozambique is home to approximately 23 ethnic groups, each with its own distinct language all of which are of Bantu origin (Ngunga & Bavo, 2011). For example, the mother tongue of 93.5% of the Mozambican population is a Bantu language compared to 6.5% who use Portuguese as their primary language. And, only 40% of the country's total population speak Portuguese with varying degrees of fluency (Ngunga & Bavo, 2011).

However, since Portuguese is the country's official language, it is also the language used in public services including health services and importantly for this study, it is the language used in the PGB as a national ASRH programme. Therefore, this raises questions regarding the relationship/connection between the continuing ASRH problems and its

1 The Ministry of Health (MISAU) is responsible for the PGB activities in health centres.

2 The Ministry of Education is responsible for PGB activities in Schools.

3 The Ministry of Youth and Sports is responsible for PGB activities in communities.

communication strategies. It is as such prudent to establish if the programme has taken the country's complex cultural realities and diversities into account.

Recent studies indicate culture plays an important role in enhancing effective communication strategies<sup>4</sup> for health campaigns (Arellano-Morales, et al., 2016; Prilutski, 2010; Schwartz, Lowe, & Sinclair, 2010; Beach, et al., 2005). There is a consensus among social scientists that culture should be taken into account when practicing and theorizing health communication (Uskul & Oyserman, 2009; Andrulis & Brach, 2007) because the cultural characteristics or features of a group are directly or indirectly linked to health-related priorities, decisions, behaviours, and/or with acceptance and adoption or rejection of health campaign messages (Pasick, et al., 1996).

However, despite the recognition of culture in enhancing health communication strategies, there is little evidence that supporting such a focus exists. Therefore, Prilutski (2010) and Kreuter & McClure (2004) recommend future studies must be developed on how to approach basic programme message delivery so that it is compatible with a group's cultural norms and values. It was also recommended that further research should focus on communication strategies, channels and methods of health intervention (Harrington, 2016; Arellano-Morales, et al., 2016; Chandra-Mouli, et al., 2015; Prilutski, 2010; Kreuter & McClure, 2004; Bernardt, 2004). This study builds on these recommendations, contributing to the literature by analysing the PGB's communication strategies in order to illuminate to what extent culture has informed them.

As such, the study was guided by the following aims:

- (i) examine PGB communication strategies by analysing the communication process used by peer educators when delivering health messages;
- (ii) identify cultural challenges discussed by peer educators and adolescents when delivering and receiving health messages; and
- (iii) reveal the implications of these challenges for the PGB.

### **Theoretical framework**

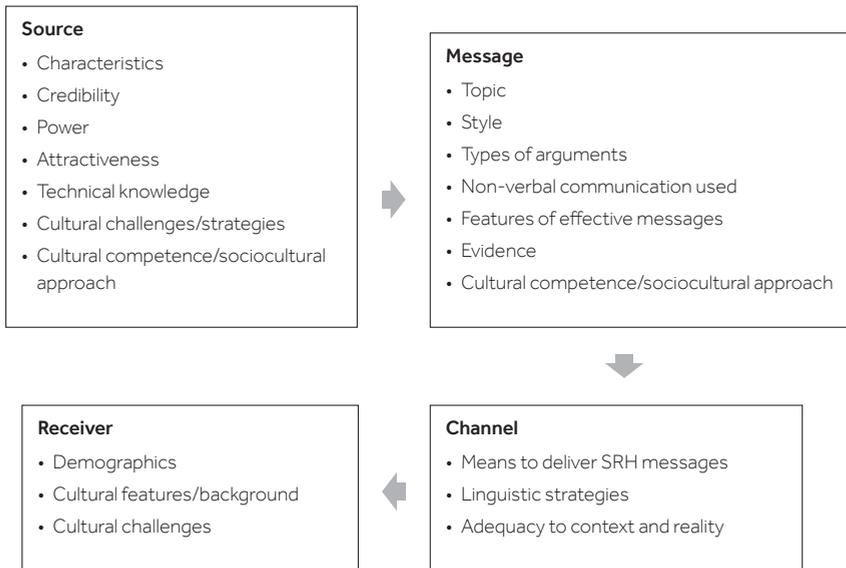
My theoretical framework builds on an adapted version of McGuire's Communication/Persuasion Model (McGuire, 1981). McGuire's communication/Persuasion model provides an effective way to analyse health campaign communication strategies (Elder, et al., 2009; Chen, et al., 2008; Corcoran, 2007). This model contains a communication and persuasion matrix with input and output factors. Communication input factors comprise five separate stages of communication: source, message, channel, receiver of messages and destination. These input factors provide options for health message educators to select and manipulate when delivering health messages. This is useful for health educators and practitioners to identify and consider strategies best able to generate good outcomes of health campaigns (McGuire, 1981). The input factors lead to the impact comprising 13 output factors and/or desired health outcomes, namely:

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4 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).

tuning, attending, liking, comprehending, generating, acquiring, agreeing, storing, retrieval, decision making, action, post-action and converting.

This study uses four input variables: source, message, channel and receiver (see figure 1). The destination input is not used because it is related to the desired outcome of the message on receiver. For this study, only the presented input factors related to the communication process are crucial for analysing the communication strategies used by peer educators to deliver health messages to adolescents in the PGB.



**Figure 1:** The proposed McGuire's Communication/Persuasion Model using its 4 input factors

### Context of the Study

In April 2016, the study was conducted in Nampula, a northern Mozambican province (see figure 2). Nampula has a population of 3,985,613 and Makhuwa constitutes the main cultural group and language (INE, 2017). Nampula was chosen because it is the biggest province in the northern region. Also, Nampula is one of the most affected provinces by adolescent sexual and reproductive health problems including premature marriage, early pregnancies and HIV and AIDS among adolescents (UNICEF, 2015; INS, 2009). In addition, around 18% of Mozambican adolescents and youth are from Nampula (Cau & Arnaldo, 2014).



**Figure 2:** Map of Mozambique  
Source: Google Maps

## Research design

This study made use of a qualitative case study approach. A case study is research on a case in real life, actual context or setting and over a period of time, using a variety of data sources (Creswell, 2013; Yin, 2013; Baxter & Jack, 2008). The choice of this methodology was influenced by the fact that qualitative case studies enable researchers to explore, evaluate and understand phenomenon using data from several sources, allowing in-depth understanding. Moreover, qualitative methods are useful in studies when little information exists about the phenomena (Creswell, 2013). This is applicable to the current study, in which there is a paucity of research regarding the relationship between communication strategies and the cultural inhibitions to effective message delivery within sexual education. A case study approach is therefore relevant for the study of the PGB in Mozambique. The cases for the study comprise two schools. One of the schools is in the city of Nampula (Escola Secundária 12 de Outubro), while the other is located in Rapale village (Escola Secundária de Rapale), which is 18km from Nampula city.

## The sample of the study

Participants of this study were individuals related to the PGB in Nampula. These included programme project officers, peer educators (sources of the messages in schools), and programme beneficiaries or adolescents in schools (receivers of the messages). Table 1 provides an overview of the main respondents' characteristics.

Participants	Education	Age	Gender M:F	Time in PGB	Total
Peer educators (sources)	High school	18-24	6:14	1-5 Years	20
Adolescents (receivers)	High school	12-17	9:15	2 weeks - 4 Years	24
Project officers	Graduate degree	25-35	1:2	1-3 Years	3
Total					47

**Table 1:** Participants' characteristics

In-depth interviews were conducted with three programme officers from the Provincial Departments of Health, Youth and Sports, and Education and Human Development. These interviews helped me identify schools where PGB services were provided.

From these interviews, I obtained purposeful samples and chose the schools to be studied. One was selected in the capital city (Escola Secundária 12 de Outubro) and one school in the nearest village outside the capital city (Escola secundária de Rapale). This was done in order to ensure rural-urban diversity. A purposeful sample is a selection of information-rich cases for in-depth study (Palinkas, et al., 2015). In this instance, by following the participants' sample criteria, I selected individuals related to the PGB. This was valuable because it added credibility to a sample when the potential purposeful sample is larger

than one can handle.

Thus, twenty four (24) adolescents and twenty (20) peer educators were selected based on the following criteria:

- (1) Peer educators had to have at least one year's of fieldwork experience;
- (2) PGB adolescents had to be aged between 12 and 17 years, and must have attended the programme for at least two weeks; and
- (3) Respondents had to be residents of Nampula province.

### **Data collection**

Data was collected in three ways: firstly, by interviewing the three programme officers using in-depth interviews. The in-depth interviews were conducted to better understand programme activities and their 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, and indicate the schools and health centres to be studied and explain those choices.

Secondly, data was gathered through focus group discussions with peer educators and adolescents at the selected schools. Focus group discussions are a useful way of listening and learning from participants, enabling the researcher to more fully understand the participants' meanings and interpretations (Gill, Stewart, Treasure, & Chadwick, 2008). Three focus group discussions (comprising 8 participants each) were held with adolescents considering their position as receivers of the health messages. In addition, three focus group discussions occurred with peer educators (two with 8 participants and one with 4) given their role as the source of messages.

Participants of these focus group discussions were asked questions on the following topics:

- (i) communication strategies used by peer educators to deliver ASRH messages in the PGB;
- (ii) cultural challenges peer educators and adolescents identify when delivering or receiving health messages;
- (iii) and the implications of the identified cultural challenges for the PGB.

Interviews with the programme officers and peer educators were conducted in Portuguese, the country's official language and the interviews with adolescents were either conducted in Portuguese or in Makhuwa, according to their preferences. All interviews were tape recorded.

Thirdly, non-participant observations were conducted with two peer educators, with 2 and 5 years of field work experience, providing health messages to adolescents. One was situated in Nampula city and the other in Rapale village. This allowed me to observe the peer educators' communication strategies in action. Importantly, it also allowed me to compare what peer educators and adolescents said during the focus group discussions, with what they actually did.

On the whole, the data collected revolved around the three main objectives of this study. The questions were also framed using the four input factors of the McGuire Communication/Persuasion Model as presented next:

**Sources of messages:** What channels do they use to transmit messages? What are the peer educators' characteristics? What cultural challenges do peer educators identify when delivering health messages? 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, arguments and style of messages are used by peer educators to deliver messages? What language is used? What non-verbal communications are used? The features of effective communication are: accuracy, availability, balance, consistency, cultural competence, evidence-based, reach, reliability and repetition. But what features of effective communication strategies are actually present?

**Channels:** These are means or methods used by peer educators to deliver health messages. However, are they adequate to ascertain reality and context?

**Receivers:** How do adolescents describe/characterise peer educators? 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 analysis**

Data were analysed thematically using Nvivo Pro11. After the transcription of data, it was necessary to translate 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.

### **Ethical considerations**

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. I also obtained written informed consent from all participants. Anonymity and confidentiality were safeguarded and interviews were conducted in locations requested by the respondents.

### **Results**

Communication strategies of the PGB

The communication strategies of the PGB in Nampula were obtained via the four input factors of the McGuire's Communication/Persuasion Model – source, message, channel, and receiver of the message.

Sources of messages

My data revealed the majority of adolescents consider peer educators to be knowledgeable, inspiring confidence as this excerpt reveals:

*"I trust the peer educators. I really trust them. They have knowledge about many things"*  
(Adolescent Marta, 2016).

Conversely, a few adolescents admitted they sometimes consider peer educators as lacking respect for their community by openly discussing sexuality:

*“I felt shame and uncomfortable talking about sexual orientations and other SRH issues. I learned at home that these issues are only talked by parents, adults and elders” (Adolescent Alice, 2016).*

### Messages

According to all study participants, the messages transmitted by peer educators are mostly preventive information about protection from HIV and AIDS, STIs, how to use condoms, negotiation skills with a partner, avoidance of early marriage and pregnancies:

*“We learn to avoid early pregnancy, delay first sexual relation, use condom. I also learned that at home, when the man says, “I want too many children”, for example, five children, I learned that a person who can decide is not only the man; two people can decide how many children they want to have. The woman has also the right to decide. This means that if a person gets married, she could still have rights. I learned this, if a person gets married, she can have reproductive rights at home, not those things they say in the community that woman has no right to decide anything” (Adolescent Lily, 2016).*

At the same time, all peer educators indicated they refrain from talking about adolescents’ sexual orientations because people feel uncomfortable talking about this topic due to their culture.

Peer educators’ and adolescents’ responses demonstrate PGB health messages are mostly delivered in Portuguese and only sometimes in Makhuwa, the local language spoken in Nampula. Makhuwa is used when adolescents have difficulty understanding Portuguese, or in the presentation of a play because it is common knowledge Makhuwa is spoken by most inhabitants of Nampula.

Additionally, non-verbal communication such as videos, CDs, posters and flyers are used by peer educators to aid in delivering health messages. All non-verbal communication in the PGB is in Portuguese. PGB’s non-verbal materials such as posters allow adolescents to read the main health messages without the peer educator’s explanation. For instance, one of the PGB’s posters entitled *“Tens direito a usar o preservativo”*, which means “You have the right to use condom”, advises adolescents and youth to talk with their sexual partners about the importance of condom use for preventing pregnancy, early marriage, and STIs, including HIV and AIDS.

It further points out condoms are free in youth friendly services called *‘serviços amigos do adolescente e jovem’ (SAAJ)*, in Portuguese. Condoms are also available free of charge at ‘PGB safe corners’.

Health messages delivered by peer educators cover seven out of the nine features of effective communication strategies. These are: accuracy, availability, balance, consistence, reach, reliability, repetition. For instance, the adolescents in this study can describe and explain what they have learned in the programme without any difficulty.

However, at the same time, two features stand out as problematic: sociocultural

approaches and evidence-based information. Interviews with peer educators reveal they fail to take into account sociocultural approaches and they rarely provide substantiating evidence when conveying health messages. For instance, peer educators do not utilise the cultural background of adolescents when delivering health messages. Instead, they only criticise initiation rites orientations, as illustrated in the following excerpt:

*“We try rescuing those who are not there yet, rescue with this information, we encourage even those who arrived there; we tried to explain not to follow the wrong path from the initiation rites. We tell them to: respect their parents, use condom, not to give up going to school and use contraceptive methods”* (Peer educator Sandra, 2016).

### Channels

Participants’ answers and my own observations indicate that interpersonal communication is the preferred method used by peer educators to deliver health messages. Interpersonal communication includes one-to-one or small group communication. Group messages are delivered in classrooms through the following channels:

*“We use campaign face-to-face, speech, theatre, showbiz and debates to deliver ASRH messages in the PGB”* (Peer educator John, 2016).

Individual conversations do occur after group conversations if an adolescent has a health issue needing further discussion in private. Individual conversations are held in a space called “*canto seguro*” meaning safe corner. Within this safe corner, the topics presented in group are discussed in more detail for a deeper understanding of the adolescent’s health issues. If the peer educator notes the adolescent has a health problem or needs to receive more health advice, (s)he sends them to youth friendly health services.

### Cultural challenges encountered by peer educators and adolescents

Participants’ answers reveal that the main cultural challenges hampering the effectiveness of the PGB in both Nampula city and Rapale village are: initiation rites; taboos surrounding sexuality; condom use; language and health terminologies; as well as forced marriages shortly after the initiation rites..

### Initiation rites

Initiation rites are the main cultural challenge for both peer educators and adolescents in effectively sending and receiving information in the *Programa Geração Biz*. Female initiation rites occur after girls’ first menstruation, no matter what their age. Conducting the initiation rites results in adolescents experiencing sexual relations, marriage and pregnancies at an early age:

*“In the initiation rites, the “mwali”<sup>5</sup>, which occur when the girl has the first period, in spite of her age, they mainly teach how to take care of the husband; to not deny anything to the husband; to serve the husband; what is the best food; the food should be sauce, you should serve first to*

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5 Mwali is a name for girls’ initiation rites in Makhuwa culture

your husband; serving him in bed. There are also other methods, how to dress, how to serve your husband, how to dress for your husband before having sexual intercourses. That is why when girls finish “mwali”, they want to marry. That is also why parents here also have those things in mind that after girls come out of “mwali” they can already be married. There are a lot of incentives for marriage, what they can do. It is like you’re grown-up; you can now learn how to serve your husband. You do everything for your husband. You are already prepared. That is what they teach us” (Adolescent Marta, 2016).

Sex and sexual issues as a taboo

Another cultural challenge identified by both peer educators and adolescents are the taboos surrounding sexuality. For instance, peer educators and adolescents say talking about sex and sexuality is not common or accepted in their community. Sex and sexuality issues are sensitive topics and they are not to be discussed openly:

“Sexual issues are not to be spoken openly in our houses and communities” (Adolescent Marcos, 2016).

Those who do openly discuss sexuality, such as peer educators, are prone to accusations from the community (and some adolescents) that they lack respect:

“It is a very hard task to talk about sex in Nampula because as a woman and having to talk about sex where there is a lot of men they gaze at you as if you were mad and afterwards they look at you as if you were a prostitute. In some occasions people find us strange when we talk openly about sex. In some communities, it is understood as lack of respect” (Peer educator Isabel, 2016).

This may adversely affect the reputation of the peer educators and result in name calling related to sexually transmitted infections such as HIV and AIDS.

Condom use

Participants of this study revealed condom use is a challenge due to religion, initiation rites orientation, and the community’s belief about its harmful purpose. These communities are accustomed to families having many children so contraception is not viewed as anything positive. For instance, peer educators say the non-use of condoms is related to religious orientations. In Nampula, and most of northern region of Mozambique, the majority of population is Muslim:

“I also faced a challenge related to condom use. A Muslim told me that using condom in his religion is haram, which means is sin” (Peer educator Maria, 2016).

Moreover, from adolescents’ responses in both schools, I can infer that initiation rites lead to a non-use of condoms, which is considered a barrier:

“The male instructors in the initiation rites say that “here you grew up. When you get there you can marry. I was taught that “no barriers” should exist when having sexual relations” (Adolescent Thomas, 2016).

Participants also abstain from condom use because of their alleged negative impact on the community's economy due to a reduction in the birth rate:

*“Yes. We have been through a situation a couple of weeks ago where the community members accused us of telling people not to have kids. They said everybody would be old and they wouldn't be a younger generation any longer and nobody would produce in their farms. They need labour. They also need labour for other areas, like electricians for example and if everybody at the community uses condom at the same time, no one will continue working in future. There will be no future at all”* (Peer educators Maria and Isabel, 2016).

Additionally, difficulties in having people use condoms are related to rumours surrounding condoms. One story, relates that HIV and AIDS contagion is purposely inserted inside condoms, and people refuse to listen to “the truth” when the topic is discussed, as interviews with peer educators revealed:

*“I found that the biggest challenges I had is related to the condom use. It is very hard to get them to understand about the importance of the usage of condoms because, some think that HIV is inside condoms and others don't even listen to you when you talk”* (Peer educator John, 2016).

Language and health terminologies

In addition to the poor Portuguese language skills, language and health terminologies are yet another challenge identified by the participants of the study as shown:

*“Not only that because the peer educator's handbooks is in Portuguese; there is another problem when it comes to talk about the difference between HIV and AIDS, because in local languages we use “AIDS” to refer to “HIV” as if AIDS and HIV were the same word. “AIDS” would refer to HIV and they assume that AIDS is the same as HIV. Once somebody is tested HIV positive, they think he/she has already AIDS”* (Peer educator Isabel, 2016).

This confusion between HIV and AIDS and the lack of translated health terminologies in Makhuwa, results in some people refusing to believe what the peer educators say and therefore do not pay any attention to them.

Parents' habits to force girls' marriages

Participants also identified parents as a significant challenge due to the local habit of marrying girls as soon as they pass through the initiation rites, despite their age:

*“Many parents force their children to marry after they finish the initiation rites”* (Peer educator Shaqira, 2016).

Peer educators' ways to deal with the cultural challenges

In relation to the ways peer educators deal with the identified challenges, peer educators' responses show that their communication strategies do not have a sociocultural approach so they leave cultural challenges unaddressed. They ignore such challenges and continue transmitting messages in the same way without looking into cultural aspects of the adolescents. This is shown below:

*“We try rescue those who are not there yet, rescue with this information. We encourage even those who arrived there. We tried to explain them not to follow the wrong path from the initiation rites. We tell them to: respect their parents, use condoms, not to give up going to school, and use contraceptive methods” (Peer educator Sandra, 2016).*

Implications of the challenges for the PGB

Peer educators’ responses point to the challenges interfering with effective delivery of the PGB key messages. For example, peer educators say that when they have problems related to language and health terminologies they skip the topic and move on to an easier one:

*“Peer educators have problems with difficult words in the PGB peer educator’s handbook. It would be best if those difficult subjects were in local languages. When we were recruited and trained they told us that they would visit us as to improve our next sessions. Unfortunately, the regular trainings are not happening. And we ended up jumping those issues because we did not know how to explain in Makhuwa, and if you ask us about them we will not know the answer, it is difficult” (Peer educator Cecília, 2016).*

Adolescents’ responses reveal they become confused with the different and opposite orientations they receive from the PGB and from the initiation rites. This may deter some adolescents from attending the programme. Moreover, these challenges also influence the way adolescents perceive the PGB peer educators – as people without (cultural) knowledge:

*“Many adolescents with the information from initiation rites when they receive this kind of information from the peer educator, their tendency will be to give up. They think that the peer educator is not telling them anything! I was taught in a way and he is telling me things differently, especially when it is said by a young person because we value the knowledge of an adult” (Adolescent Marcos, 2016).*

## **Discussion**

This study examines the communication strategies of the PGB in Nampula. This was done in order to identify cultural challenges peer educators and adolescents face when delivering and receiving health messages. The study was based on four input factors of McGuire’s Communication/Persuasion model: source, message, channel, and receiver. Data generated from this study demonstrate peer educators are generally viewed by the majority of the adolescents as people who have knowledge and confidence. The sources of message credibility, attractiveness and power are considered important for effective message delivery (Corcoran, 2007; McGuire, 1981).

The majority of adolescents participating in this study see peer educators as role models and want to be like them. This is confirmed by literature (Warwick & Aggleton, 2004; Tunner & Shepherd, 1999). However, as pointed out by adolescents Marcos and Alice, a minority does not appreciate or trust peer educators, especially when they deliver messages involving sensitive cultural topics such as sexuality.

For example, Marcos complained he does not trust peer educators' emphasis on delaying sexual relations or avoiding early marriage. These are very different from the orientations he has received during the initiation rites. There, initiation rites masters say 'you have grown-up, you are ready to start sexual relations, and you can marry'.

The attitudes held by Marcos and Alice reflect community taboos around sexuality and cultural norms prescribing that only adults and elders speak about these issues (Silva, 2016). Sexuality information provided by a respectful community member, such as initiation rites educators is perceived as credible. It is not to be questioned. The same cannot be said for information given by a peer educator who is from the same age group. Consequently, most adolescents may tend to ignore peer educators' messages in terms of delaying sexual relations or postponing marriage. This is because their cultural background values the word or advice imparted by adults and elder people (Altuna, 2009; Martinez, 2008; Rosário, 2007). Therefore many adolescents view peer educators as lacking knowledge in this area. Consequently, this study reveals using peer educators can conflict with cultural norms regarding who should be allowed to teach SRH issues.

The interpersonal method used by peer educators to transmit messages in the PGB is considered adequate in context and reality as it allows both receivers and sources to share ideas in a normal conversation (Corcoran, 2007; Berry, 2007). Interpersonal communication is advantageous and appropriate for enhancing behavior change not only because of the physical presence of the source of message, but also because it is delivered by a person from the targeted group (Hanan, 2009; Munodawafa, 2008). Thus, the PGB health messages are transmitted face-to-face by peer educators, aged 18-24. This method of addressing adolescent health concerns appears to be effective. It also enables peer educators to gain foundational skills and confidence in communicating SRH issues – both in group and individual settings (Backett-Milburn & Wilson, 2000).

Theatre is another method used by peer educators to deliver health messages in the PGB. According to the peers, performing a role on a specific topic catches the attention of adolescents allowing information to be passed while they are being entertained. The strategy of using entertainment-education is considered a positive and popular method used in many youth health interventions (Cardley, et al., 2013; Glick, Nowak, et al., 2002). Preventive messages transmitted by peer educators to adolescents in the PGB are not only within the line of studies on adolescent health interventions (Hatcher, et al., 2011; Kirby, Laris, & Roller, 2007) but also in line with the PGB peer educator's handbook, communication strategies to prevent HIV and AIDS, and the national strategic plan on HIV and AIDS response – 2015-2019 (Governo de Moçambique, 2003; Pathfinder, 2013; Governo de Moçambique, 2015). All three sources state communication strategies used to deliver preventative messages about HIV and AIDS in Mozambique should cover a myriad of topics. Not surprisingly, topics include sexual abstinence; engaging in sex not involving penetration; condom use; reduced number of sexual partners; delaying sexual intercourse; develop adolescent life skills; and involving adolescents in the definition and participation of communications activities within the community. In providing health services for developing countries, prevention is the first measure, followed by treatment

and follow-up. Most adolescents and peer education health interventions focus on preventive health messages as discussed earlier (Sawyer, et al., 2012; O’Dea, 2005). Current PGB message transmission is in line with recommendations on how to deliver health information in the receivers’ own language (Hanan, 2009; Munodawafa, 2008), given that PGB peer educators deliver messages in Portuguese and sometimes in Makhuwa, a local language. However, peer educators and adolescents report they often face some difficulty related to language and health terminologies when translating PGB health messages from Portuguese to Makhuwa. For instance, Isabel, a peer educator, pointed out that translating the information from Portuguese to Makhuwa is not the only problem they encounter. The absence of proper health terminologies they use in Makhuwa is yet another issue. This results in the peer educators using the same health terminology to refer to HIV and AIDS.

Moreover, peer educators individually translate health terminologies into Makhuwa. Consequently, translated health terminologies for the same things are not used or understood by all peer educators as a common group. Furthermore, peer educators skip PGB topics when they experience language difficulties, as mentioned by the peer educator Cecília.

To address this, it is necessary to translate the PGB peer educator’s handbook with a glossary of health terminologies from Portuguese to Makhuwa. This would be in line with Kreuter & McClure (2004) recommendations about linguistic strategies when delivering health messages. Linguistic strategies are important to make health communication programmes and materials more accessible by providing them in the dominant language of a particular audience segment. Additionally, it is also important to provide refresher training/debriefing sessions with peer educators.

Non-verbal communication such as posters and flyers are also used by peer educators. The literature reveals non-verbal communication can replace verbal communication in situations where is impossible or inappropriate to talk. This would include supporting and validating verbal messages; communication of our feelings and emotions; regulating interactions and providing feedback; negotiating relationships in respect of factors such as dominance and control; and maintaining self-image (Corcoran, 2007; Berry, 2007). However, the availability of those messages only in Portuguese sometimes poses challenges for those adolescents with reading difficulties. Therefore, these materials should be also provided in the languages of the target audience. In this regard, the translated messages from Portuguese to Makhuwa could be transmitted on local radio and television as suggested by the literature. For example, the NRC (1996) indicates health programmes utilising radio for transmitting and promoting health messages in the local languages proved to be very effective throughout Sub-Saharan Africa.

PGB health messages are conveyed using a clear style and objectivity as recommended (Corcoran, 2007; Kreuter & McClure, 2004). Message clarity is supported by the fact that each adolescent could express what they have learned in the PGB without any problem. For example, adolescents pointed out that the programme is an appropriate place to learn SRH issues and life skills as revealed by adolescent Lily.

Lily stated she has learned that in a marriage relationship, both partners have the right to decide on how many children they want to have, and not just the man, as commonly happens in her community. Her response made me reflect upon the potential of the PGB to change gender norms as suggested by Loforte (2007). Gender norms in Mozambique clearly benefit males as women are expected to be submissive to men (Arnfred, 2011). Thus, I question the real chance Lily the adolescent will have to apply what she has learned in PGB in her community. This is because in most Mozambican cultural groups, a woman is seen as someone who lacks the power to decide anything (Silva, 2016).

In many Mozambican cultural groups, including the Makhuwa, girls are taught to be submissive to their fathers and husbands and they are expected to have children soon after marriage (Silva, 2016). Moreover, they are also taught they have no power to decide how many children they should bear. Although this is a clear violation of their human rights, it is a time-held cultural norm (UNESCO, 1994). In this context, it will be difficult for just a few girls from PGB to change community perspectives on gender roles. To address this, there is a clear need to equip community members with relevant knowledge on human rights. Simply providing girls with this knowledge is not enough to stimulate change. By ignoring attitudes of their parents, initiation rites educators, and the wider community, it will be difficult, if not impossible, for girls to apply their acquired knowledge as the community will continue to have a distinctly different opinion on the same issue. In support of this view, Warwick & Aggleton (2004) point out the importance of community training on relevant SRH information to facilitate peer educators' work.

Despite the fact the messages are clear and in line with Mozambique's official communication strategies concerning HIV and AIDS (Governo de Moçambique, 2003) and the National strategic Plan for HIV and AIDS response (Governo de Moçambique, 2015), peer educators do not take into account the sociocultural approach when delivering health messages to adolescents. The sociocultural approach presents health messages in the context of social and cultural characteristics of the target population (Dutta, 2007; Kreuter & McClure, 2004). For example, both peer educators and adolescents identified initiation rites, sex and sexual issues as a taboo. Also included here are condom use, language and health terminologies, as well as parents who force their children to marry following the initiation rites. Combined, these issues form the principal cultural challenges for the *Progama Geração Biz*.

The cultural challenges identified by both peer educators and adolescents confirm the study results conducted by Murove, et al. (2010). The researchers identified marriage practices, rites of passage, family and some religious orientations about non-use of condoms as cultural practices potentially posing risk to children in Mozambique. These identified cultural challenges are considered harmful (Longman & Bradley, 2016; Ahmed, 2015; Walter, 2012; Cottingham & Kismond, 2009; UNICEF, 2005). The term 'harmful traditional practices' refers to "all behaviour, attitudes and/or practices negatively affecting the fundamental rights of women and girls. This includes: their right to life, health, dignity, education and physical integrity" (Zimbabwe Youth Council, 2014: 1-2). These, as a rule, include mainly traditional practices such as female genital mutilation, early

marriage and early pregnancy, nutritional taboos and practices related to child delivery, preference of sons as well as its implications such as female infanticide and honour killings (Zimbabwe Youth Council, 2014; UNICEF, 2005). Although the peer educators are aware of these cultural challenges, they do not adopt a more sociocultural approach to reduce cultural barriers. Peer educators maintain “they keep on advising adolescents not to follow the initiation rites orientations”. From this response, it is obvious they are ignoring the adolescents’ cultural background. Merely transmitting PGB health messages will not lead the PGB to attaining effective health outcomes. This is because initiation rites orientations lead adolescents into early marriage and consequently to early pregnancies with the support of their parents, family and community. In their minds, this is a “natural thing” to be done after girls pass through the *mwali* initiation rites in Makhwa culture (Martinez, 2008). As a consequence of early marriage, girls are also expected to bear children as soon as possible after they are married (Ahmed, 2015; Kotanyi & Krings-Ney, 2009; Martinez, 2008).

Initiation rites orientations also lead to non-use of condoms by adolescents. This is because girls and boys have learned sex must be completely natural, without any barriers. This may lead to a view that some culture and society norms influence HIV risks (Parker, Easton, & Klein, 2000). The Bagnol & Mariano (2008) study also notes female traditional practices in Mozambique are viewed as fundamental to the construction of female identity, eroticism and pleasure, and this influences the preference for sex without using a condom. Therefore, in my view, initiation rites orientations such as (i) you have grown-up and can start your sexual life; (ii) you have grown-up and you can marry and have babies; and (iii) sex should be natural – without a barrier such as a condom are, in fact, the primary challenges for the PGB main communication strategies. Those strategies are: (i) delay first sexual intercourse, (ii) avoid early marriage and pregnancy; and (iii) use condoms to avoid STIs, including HIV and AIDS. These conflicting orientations – PGB education and initiation rites – are exacerbated by the fact peer educators do not take into account sociocultural approaches, even though they are aware of and acknowledge their existence. This leads to confusion amongst adolescents and impedes effective message delivery by peer educators. This, in turn, may contribute to lower student attendance or even leaving the PGB programme altogether. Consequently, I consider the identified cultural challenges as contributing to the PGB’s failure to attain its desired health outcomes.

As shown in table 2, the respondents’ answers concerning the three initiation rites orientations reveal traditional rites discourses contradict the communications of the PGB. This occurs without ever entering into a dialogue to see how these contradictions might be addressed.

PGB orientations	Initiation rites orientations
Delay first sexual intercourse	You have grown-up and can start your sexual life
Avoid early marriage and pregnancy	You have grown-up and you can marry and have babies
Condom use to avoid STIs and HIV/AIDS	Sex should be natural and without any barrier

**Table 2:** PGB discourses contradicting initiation rites orientations

The distinction of modernity, referring to PGB values, and tradition, referring to initiation rites teachings, should not lapse into a dichotomy with ethical overtones. If we adopt Stroeken's (2010) view of change through mutual learning, the situation might resolve itself. It is the "static" character of the initiation rites that lead to cultural misunderstanding while at the same time the PGB does not take into account these cultural factors. The initiation or transitional rituals are very important in the rural areas of the country. This is because they not only focus on the role of women and men in society and how to be accepted as an adult, but also on SRH issues.

In the Makhuwa culture, youth need to pass through initiation rites or transitional rituals in order to be considered and accepted as an adult (Silva, 2016; Martinez, 2008). Thus, traditional rites are to be perceived, in the case of Mozambique, as a "formalized" informal education provided in rural communities. This exists in contrast to the formal education provided by schools. Because both modernity and traditional values can learn from each other and change, I suggest training should be initiated to overcome identified cultural challenges. Therefore, relevant SRH issues should be discussed with initiation masters and the broader community.

In my view, peer educators should develop a bridge between the messages they are disseminating and the cultural background of the adolescents to increase communication effectiveness. In other words, peer educators should link initiation rites and PGB information by using a sociocultural approach to educating youth. In this regard, adopting sociocultural approaches is a key feature of effective health communication strategies (Munodawafa, 2008; Dutta, 2007). For instance, when openly addressing culturally sensitive topics such as sex or sexuality, peer educators might apply audience segmentation. This is a process of dividing large and heterogeneous population into smaller, more homogeneous subgroups (Kreuter & McClure, 2004).

Thus, peer educators could use the cultural feature of educating boys and girls separately (Silva, 2016; Rosário, 2007) when sharing SRH messages. In most Mozambican rural communities, research reveals the family and community provide daily knowledge for the integration of youth into the community. This is usually based on their gender, although the contents taught are complementary (Silva, 2016; Rosário, 2007). From the early stages of development young people in Makhuwa communities are taught gender roles. According to their age, girls observe and practice women's daily activities and boys observe and follow men's activities in the community. It would be useful for peer educators to implement this aspect when delivering health messages during the PGB sessions. This would be especially the case when talking about sex or sexual issues within these communities. Openly discussing sexuality is a taboo and should only be spoken

about with people of the same sex. Instructions about sex, sexuality and related issues are taught by matrons or initiations rites educators during the rites for boys and girls. Therefore, a criterion of audience segmentation could be gender. Thus, male peer educators could talk with male adolescents. Concurrently, female peer educators could talk about sexual issues with female adolescents. Non-SRH topics could be delivered in group sessions with both male and female adolescents. This solution would help make PGB messaging more effective and would also allow peer educators to be viewed with more respect.

Another possible solution in addressing initiation rites challenges might be training initiation rites masters about the PGB main health messages. As a result, they could pass on the same information to the youth during the initiation rites. If initiation rites and PGB orientations were in harmony, adolescent SRH issues could be addressed more effectively.

Additionally, in a community-based approach (Dutta, 2007; Diop, 2000), parents and community members of great influence should be trained on SRH to enable their children to talk openly about these issues. It is my opinion that the main cultural challenges identified in Nampula could be overcome if initiation rites masters and prominent community members were equipped with the same knowledge as peer educators. This is particularly important since initiation rites masters/traditional educators are well respected in their communities.

I also believe peer educators could use short stories as a local cultural feature to deliver their messages. Only one female peer educator used oral short stories related to the SRH issues when delivering health messages. Recounting short allegorical stories is a truly effective means to deliver knowledge in oral societies (Altuna, 2009; Rosário, 2008).

For instance, most Mozambicans have one Bantu language as a mother tongue and receive knowledge by oral means (Ngunga & Bavo, 2011). Spoken short stories are not only a good way to transmit knowledge on SRH, but also are a clever way to entertain young people while educative messages are conveyed to them. This is also in line with recommendations on community education addressed to young people (Altuna, 2009; Rosário, 2007).

Additionally, peer educators fail to provide scientific evidence to support the claims made in their messages to the youth they are instructing. In my view, peer educators should start their sessions by talking about the cultural aspects of the adolescents' lives, making reference to their community's practice of advocating early marriages which lead to early pregnancies. Then scientific evidence should be brought forward outlining the negative impact early pregnancies pregnancy can inflict upon many adolescents. This evidence could entail presenting numbers of adolescents in the country affected with SRH problems.

Thus, during non-participant observations, I was able to deduce that peer educators only talk about the negative impact or consequences of early pregnancies without bringing forward relevant data on the issue. This happens in spite of the fact of there being several teaching aids available such as videos, posters and illustrations to provide plausible

proof about the negative impacts of early marriage and early pregnancy. Presenting scientific evidence on these issues would help adolescents better understand the issue from a logical perspective. It should also help young people understand this as a problem affecting others like themselves and to take preventive measures (Yusof, et al., 2008; Corcoran, 2007).

Moreover, scientific evidence could dispel common perceptions amongst Mozambican youth that HIV/AIDS is contained inside condoms. Pfeiffer's (2004) study states messages against condom use have taken hold in numerous Mozambican communities due to clashes with religious communities. Providing adolescents with information on relevant statistical data (e.g. "this year, 13.000 girls aged 12-15 were pregnant and 2000 were infected by the HIV because they did not use condom") will raise awareness. Perceived personal vulnerability to this problem will more than likely lead them to take preventative actions.

Nonetheless, although the messages delivered by peer educators do not present two key features of effective health communication strategies – the sociocultural and evidence-based approaches – they present most features of effective communication strategies. These features are:

- accuracy – because the messages presented are valid, actual, relevant, and clearly presented without judgement;
- availability – these health messages are available to the beneficiaries when needed because the peer educators are students of those schools and known to the student body;
- balance – although there is a lack of scientific evidence, messages are appropriate, while benefits and risks of potential actions are presented;
- consistency – the content of these messages remains consistent over time and compatible with other sources;
- reach – messages are available to a large number of the target group because these announcements are delivered in classrooms and most classrooms have between 70 and 80 students in them;
- reliability – peer educators, the source of the message, are credible and their information is up to date as they take part in weekly meetings with the programme officers; and
- repetition – delivery of the message is repeated over time as recommended (Healthy People, 2010; Yusof, et al., 2008; Bearinger, et al., 2007).

This study presents some limitations as it did not look into what motivates adolescents to stay in the programme despite the cultural challenges identified. Another limitation is that the study took place in a narrow setting with a small number of respondents. Therefore, it should not be generalised to other parts of the country. However, I, as a Mozambican researcher, do perceive the cultural aspects identified in Nampula as similar to other Mozambican cultures. 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.

I 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. That is, the programme and messages should be tailored to the differing needs of the various parts of the country, according to the local sociocultural context.

### **Conclusions and recommendations**

This study reveals a myriad of cultural challenges hindering the effective communication of PGB messages. Talking about sexuality remains a taboo while sexual abstinence, condom use and early marriage continue to pose challenges. This is largely due to the fact initiation teachings and rites are completely opposite to PGB message orientations. Peer educator's communication strategies do not take into account sociocultural context and fail to provide evidence when delivering health messages to adolescents. Consequently, there is a need to create a bridge between initiation rites and PGB activities to avoid cultural conflicts.

However, these cultural challenges can be transformed into opportunities to train initiation ritual masters about adolescent SRH issues and the identified cultural challenges. Peer educators must be further trained to gain a greater level of cultural awareness and to incorporate this into ASRH education. This would allow them to act as a bridge between the adolescents' cultural background and the intent of PGB.

Also, parents and influential community members should be supplied with information and knowledge of SRH issues in order to change local norms concerning sexuality. Additionally, there is a need to translate a PGB peer educator's handbook with a glossary of health terminologies into the local languages. 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.

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