ETHNOGRAPHIC INVESTIGATION

CULTURAL AND COMMUNITY PRACTICES AIMED AT PROMOTING SEXUAL AND REPRODUCTIVE HEALTH

NAMPULA, SOFALA, INHAMBANE – MOZAMBIQUE

MAPUTO, August 2010

KULA, ESTUDOS E PESQUISAS APLICADAS LDA.

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ABBREVIATIONS

ACS	COMMUNITY HEALTH WORKER
ARO	HIGH RIK-OBSTETRICS
CPN	PRENATAL CONSULTATIONS
EPC	COMPLETE PRIMARY SCHOOL
ESH	SCHOOL WITHOUT HIV
FDC	FUNDAÇÃO PARA O DESENVOLVIMENTO DA COMUNIDADE
FNUAP	UNITED NATIONS POPULATION FUND
GDF	FOCAL DISCUSSION GROUP
HAI	HEALTH ALLIANCE INTERNATIONAL
HIV	ACQUIRED IMMUNODEFICIENCY VIRUS
IEC	INFORMATION, EDUCATION AND COMMUNICATION
ITS	SEXUALLY TRANSMITTABLE INFECTIONS
MIF	MULHER IN CHILDBEARING AGE
PF	FAMILY PLANNING
PGB	GERAÇÃO BIZ PROGRAMME
PTV	VERTICAL TRANSMISSION PROGRAMME
SAAJ	ADOLESCENT AND YOUTH FRIENDLY SERVICES
SDEJT	DISTRICT SERVICES OF EDUCATION, YOUTH AND TECHNOLOGY
SDSMAS	DISTRICT SERVICES OF HEALTH, WOMEN AND SOCIAL ACTION
SIDA	ACQUIRED IMMUNODEFICIENCY SYNDROME
SMI	MOTHER AND CHILD HEALTH
SSR	SEXUAL AND REPRODUCTIVE HEALTH
TARV	ANTI-RETROVIRAL TREATMENT
UNESCO	UNITED NATIONS ORGANIZATION FOR EDUCATION, SCIENCE AND CULTURE
ZIP	PEDAGOGICAL INFLUENCE ZONE

GLOSSARY

TERM	MEANING	LANGUAGE/LOCALITY
NAKAPA	Cloth used by women during the menstrual period	Macua/Ribáuè
KUNHUNHO	Hernia	Macua/Ribáuè
HULAS	Maidens, girls having the first menstrual period	Macua/Ribáuè
HOLAKA	Counsel/advice for girls	Macua/Ribáuè
IPITXI	Substance used to reduce the vaginal opening	Macua/Ribáuè
MAVUKA	Disease that affects babies accompanied by emaciation and wailing	Macua/Ribáuè
NKULUCANA	Herb	Macua/Mossuril
HEKOMA	Counsel/advice for girls	Macua/Mossuril
MATHUNA/MATINDJE	Stretching of the minor labia	Sena/Nhamatanda
PITAKUFA/PITAMADJUADE	Ceremony conducted with widowed women and women who had a miscarriage, is a purification act.	Sena/Nhamatanda
TXIUMBA	Disease that may develop in the genitals of the woman during pregnancy	Chopi/Zavala
XITHETHO	Kind of sterility in women	Chopi/Zavala

EXECUTIVE SUMMARY

The present report presents the results of the ethnographic investigation carried out in the districts of Ribáuè, Mossuril, Nhamatanda and Zavala about cultural and community practices for the promotion of Sexual and Reproductive Health. The investigation was conducted along ethnographic and qualitative lines centered on a socio-cultural approach. Data were collected by means of individual interviews, focal group discussions and structured direct observation covering the provinces of Nampula, Sofala and Inhambane.

The general findings of the investigation point to the following aspects:

- In all investigated localities teachings are being passed on about SSR at the level of the community, the school and the health unit, although the transmission processes vary. In the communities teachings are passed on "traditionally", by taking recourse to taboos and to permission and prohibition messages, whereas in the schools and health units these instructions are transmitted in a modern way, with recourse to the audiovisual aids and IEC material, among other things.

- At community level the transmission of teachings about SSR are based on unequal gender differentiation, meaning that there are teachings only for men and specific teachings for women.

- In the community teachings are passed on to the girls about precautions with respect to menstruation, about care during and after pregnancy and in case of an abortion, and about the roles that men and women are expected to play. Also taught in this educational environment are strategies to ensure matrimonial stability, with emphasis on the "need" to pleasure the man by taking recourse to various body techniques, such as vaginal extensions, the use of beads/collars [missangas/miçangas?] around the hips and movements during the sex act.

- Teachings passed on to the boys in the community are limited to the respect to be shown to elders, their virility and the responsibility to be assumed because of their social role.

- In Ribáuè and Mossuril in particular, the education process of the boys takes the form of initiation rites stretching a relatively long period that may last up to a month, and during this period the boys stay in a locality relatively distant from their homes.

- In Nhamatanda the passage from adolescence to adulthood does not consist of specific moments or acts, there are practices that vary from family to family and these cannot be considered as a cultural pattern being followed by the community at large.

- In Zavala the educational moment of the boys that marks the passage from adolescence to adulthood features various practices among which is the construction by the youngster of his own house, signalling the readiness for adult life, which includes having a wife. Although this practice can be seen in various families it does not constitute a cultural pattern followed by the community at large.

- The teachings are passed on by means of initiation rites, counselling and recommendations. The educational cycle for the girls starts with the appearance of the first menstruation and for the boys it varies, it is before they reach twenty years of age but it always culminates in the circumcision.

In the community the main stakeholders in education about SSR are godfathers, godmothers, matrons, practitioners of traditional medicine, fathers, mothers, grandparents and paternal uncles, traditional chiefs and religious leaders. Although in some cases (Nhamatanda and Zavala) the presence of the parents is being felt in the educational process, their role is in fact less significant than that of the other stakeholders mentioned above.

- In the Nhamatanda and Zavala communities (patrilineal societies) the grandfathers, paternal uncles and aunts are the pillars for the transmission of this knowledge to the boys whereas the patrilineal aunts and grandmothers are responsible for the education of the girls. In Nampula (matrilineal society) the education of the girls is delegated to the godmothers and matrons, contrary to what we saw in Nhamatanda and Zavala.

- The godfathers and godmothers have this role of educating and counselling boys and girls about the responsibility imposed on them by the new social status acquired through the initiation rites. The matrons and practitioners of traditional medicine are responsible for executing the initiation rites. The uncles, grandmothers, religious leaders and traditional chiefs play the role of counsellors. The relationship between the community, the school and the health unit is weak and characterized by the absence of communication, which translates into a poor use of opportunities for interaction.

- The health services available in the community are education and promotion of health through counselling corners, practitioners of traditional medicine and advice offered by ACSs and SSR activists.

- The advice passed on among youth in the community concerns mostly ways to seduce, both for men and for women, the promotion of condom use and discussions about the profile of the ideal man and women for matrimony.

- The strengthening of the SSR promotion programmes in the community should capitalize on the existence of key stakeholders responsible for SSR education. While responsible for the socialization of subjects related to sexuality it will be possible through these people to reinforce the approach of SSR at community level.

- Teachings in school focus on the prevention of premature pregnancy, condom use, abstinence, STIs and HIV and AIDS. The mechanisms used are lectures, getting pupils together, sports activities, counselling corners and Biology and Civic and Moral Education lessons.

- The main stakeholders in education at school level are the teachers and activist pupils. Both stakeholders play the same role, which consists in SSR awareness raising, promotion and education. At school the role of NGOs or the involvement of the parents or other community members, such as godmothers, godfathers or community leaders, is not being felt

- The relationship between the school and the community is poor and up to a certain point even contentious due to the way in which each of these educational environments approaches the passing on of knowledge. There is also a difference between the transmitted contents. The relationship between the school and the health unit is equally poor, given that the respective parte-a-parte? actions are not systematic.

- The health unit teaches the importance of family planning, institutional childbirth, the importance of testing and PTV. The teachings are transmitted through consultations, lectures and counselling. The

main stakeholders in the health unit are SMI nurses, doctors and activists of SAAJ. Their role boils down to the provision of services.

- As far as the relationship between the health unit and the community is concerned the district of Zavala presents a reality that differs from that in the other districts because it has a Community Health Worker (ACS) who is quite active, chosen by the community and whose task is to coordinate the realization of awareness raising activities carried out by the health unit in the community.

- Generally speaking all investigated districts show a major conflict of generations between parents and children. From the point of view of the parents the conduct of youngsters is to a significant degree negatively influenced by modernity, while from the children's viewpoint the parents do not concur with the transformations associated to cultural dynamics.

- There is a conflict between formal and traditional education. Among various examples the most significant being that formal education, even after the occurrence of the first menstruation, argues for postponing the moment where youth become sexually active and commends the avoidance of premature and unwanted pregnancies, while in traditional education the first menstruation symbolizes sexual maturity, both in terms of reproduction and matrimony.

I. INTRODUCTION

The present report presents the results of the ethnographic investigation about cultural and community practices for the promotion of Sexual and Reproductive Health carried out in the districts of Ribáuè and Mossuril (Province of Nampula), Nhamatanda (Province of Sofala) and Zavala (Province of Inhambane).

The United Nations Programme for Education, Science and Culture (UNESCO) and the United Nations Population Fund (FNUAP) in Mozambique are implementing a Joint Programme in collaboration with the Government of Mozambique, which aims at promoting a better integration of the cultural perspective in national development plans and processes, and one of the Programme's components centres on the area of SSR.

Norms and beliefs, life styles, attitudes and practices related to perceptions about health and disease, life and death, have a bearing on the way people live and make their daily choices. Pregnancy, childbirth, motherhood and sexuality are influenced by taboos concerning sex, by gender relations and by specific cultural practices, such as initiation rites, circumcision, polygamy, the purification of widows, among other things. The poor understanding and consideration of these factors in development plans and processes have limited the efficiency of interventions in the area of HIV and AIDS. The increase of the HIV prevalence rate in Mozambique, despite all efforts that have been made in terms of prevention, offers an example of the limited efficiency of interventions in the area of health.

The current investigation has been carried out on the basis of a socio-cultural approach that considers the social, cultural, economic and institutional reality individuals live in, as well as the collective knowledge accumulated by the communities and their key actors. One of the assumptions guiding the current investigation is that the sexual behavior of individuals is shaped by cultural norms and values, which areassociated with the way the reproductive sphere is organized in a determinate context. The socio-cultural approach is a key instrument in conceiving interventions aimed at culturally appropriate behavioural change.

As far as its structure is concerned, the report presents the objectives and the methodology, followed by the district profiles of the locations covered by the investigation. The results are presented in the sequel, which includes the description of the features of SSR education in the four districts and which considers three environments, namely the community, the school and the health unit. This chapter is followed by the presentation of a joint analysis of the results and finally the conclusions and recommendations.

II. OBJECTIVES

II. I GENERAL OBJECTIVE

Identify, describe and analyze the beliefs, taboos, attitudes and practices concerning sexual and reproductive health and the main stakeholders in education at the level of communities, schools and health units.

II.2 SPECIFIC OBJECTIVES

At community level

- Identify and understand the traditional systems of education about SSR, in particular sexuality, pregnancy, childbirth and motherhood;
- Identify and describe which services are present, who are the providers, the users, the link between the formal and traditional systems dealing with SSR, the opportunities and challenges with respect to strengthening the links between these systems, including prevention and care and mitigation of HIV and AIDS;
- Understand the demands of the community and the people in charge of traditional education and analyze the perceptions of traditional leaders concerning SSR education in school;
- Identify the SSR educators in the different age groups, what methods they use and compare the contents transmitted within the context of traditional and of formal education in the schools and health units.

At school level (primary and secondary)

- Identify the role and attitude of the school and the teachers towards education about SSR and HIV/ AIDS of students, including who teaches, what the contents are and the methods used;
- Identify and describe the main obstacles, needs, challenges and opportunities for integration of the traditional systems in the educational curricula concerning SSR, HIV and AIDS;
- Analyze how the school sees the inclusion of traditional education about SSR in the formal system and what the role of community educators might be in school interventions;
- Assess the extent to which the community and the people in charge know and are interested in education about SSR and HIV and AIDS, offered by the school.

II. METHODOLOGY

III.1 APPROACH AND METHODS OF DATA COLLECTION

The investigation was developed using the socio-cultural approach, as recognition of the fact that culture plays an important role in all initiatives whatsoever that seek to better understand and communicate messages or to influence behavioural change. In this specific case, this approach is relevant in conceiving tools for the integration of cultural aspects in preventive (in community and schools) and curative (in USs) health interventions, taking into account the cultural identity of the persons primarily involved in this process.

The investigation adopted a qualitative ethnographic approach involving the review of literature, data collection by conducting focal group discussions and individual interviews with stakeholders and main actors in SSR education, and structured direct observation. The in-depth interviews and focal group discussions were held with different service providers in the area of education (teachers, school directors and pupils, among whom were SSR activists), health (doctors, nurses, community health workers and activists), community members involved in providing services and education about SSR (including traditional leaders, traditional healers and traditional midwifes) and youths of both sexes.

III. 2 DATA COLLECTION PROCESS: CATEGORIES AND LOCALITIES COVERED

Data were collected in the provinces of Nampula (Ribáuè and Mossuril), Sofala (Nhamatanda) and Inhambane (Zavala). The table below shows in summarized form the categories covered by the investigation:

Table 1: Individual and Focal Group Interviews per Investigation Category

Category	**Ribáuè**		**Mossuril**		**Nhamatanda**		**Zavala**		**Grand Total per Category**
	GDF	**IND**	**GDF**	**IND**	**GDF**	**IND**	**GDF**	**IND**	
Teacher	-	1	-	1	-	3	-	1	**6**
Pupil	2	2	2	2	2	4	2	2	**18**
Guardian	2	2	2	2	2	2	2	2	**16**
School Director	-	-	-	1	-	-	-	1	**2**
SDEJT Representative		1		1	-	1	-	1	**4**
Medical Doctor	-	1	-	1	-	1	-	-	**3**
Nurse	-	1	-	2	-	-	-	2	**5**
District Representative SSR	-	-	-	1	-	1	-	1	**3**
Practitioner Traditional Medicine	-	2	-	3		1	-	1	**7**
Traditional Midwife	-	1	-	2	-	1	-	-	**4**
Matron	-	1	1	1	-	-	-	1	**4**
Traditional Chief	1	1	1	1	1	-	1	1	**7**
Religious Leader		1	1	1	-	-	-	1	**4**
Godmothers initiation rites	1	1	2	1	1	1	-	1	**8**
Godfathers initiation rites	1	1	1	1	-	-	-	1	**5**
Persons in charge of initiation rites	-	-	1	1	-	1	-	-	**3**
NGO representative		1	1	1	-	-	1	1	**5**
Total per District	**7**	**17**	**12**	**23**	**6**	**16**	**6**	**17**	**104**

IV. DISTRICT PROFILES COVERED BY THE INVESTIGATION[1]

FIGURE 1: LOCALIZATION OF THE STUDY AREAS

PICTURE

IV.1 DISTRICT OF RIBÁUÈ

With a surface area of 4,894 km², the district of Ribáuè is located in the western part of the province of Nampula bordered in the north by the district of Lalaua, in the south by the districts of Alto Molócuè in the province of Zambézia and Murrupula, in the west by the district of Malema and in the east by the district of Mecuburi (MAE, 2005).

As far as its administrative division is concerned, the district has three administrative posts, namely Ribáuè-Sede, Cunle and Iapala. The administrative posts of Ribáuè and Iapala in turn are subdivided into two localities each, while Cunle has only one locality, which means that the district as a whole has five localities. Thus Ribáuè Sede boasts the localities of Chica Sede and Namigonha and the administrative post of Iapala has in addition to its Sede [seat] the locality of Norre Sede, while the administrative post of Cunle has the locality of Cunle Sede.

FIGURE 2: LOCALIZATION OF THE DISTRICT OF RIBÁUÈ

PICTURE

According to the projected population data the district of Ribáuè had about 180,464 inhabitants [*about* 180,494?] in 2010. Combining these data with the total surface area of the district results in a population density of 36.9 inhabitants/km².

The population consists mostly of women, given that they number 91.186 while there are 89.278 men. This trend is observed in all age groups that have been taken into account.

According to the table showing the distribution of the district population by sex and age, 46.1% of the total of 180.464 inhabitants is of child-bearing age, 45.7% are youth and 2.2% are elderly. Therefore more than 95% of the population is under 65 years of age, meaning that one is dealing with a predominantly young and adult population.

Table 2: Population of the District of Ribáuè per Age and Sex

Age	Men	Women	Total	
0 - 14	43,348	39,199	82,546	45.7
15 - 49	39,560	43,526	83,085	46.1
50 - 64	4,513	6,358	10,871	6.0
65+	1,858	2,104	3,962	2.2
Total	89,278 (49.5%)	91,186 (50.5%)	180,464	100%

[1] At district level it was not possible to collect systematic information about statistical data concerning SSR of youth in general, including information vabout premature marriage, teen pregnancy and in some cases HIV and AIDS infection rates.

Source: www.ine.gov.mz
Couched in socio-cultural terms the district is matrilineal and the populations living in it belong to the lineages Amal, Amilima, Alucassi, Amirassi, Ayage, Atcheletche, Alapone, Anale and Amirole. Most inhabitants are of the Amilima lineage (nihimo). The dominant mother tongue is Emakuwa. According to data from MAE 2005 the majority of the population in Ribáuè is Muslim. The dominant mother tongue being Emakuwa, 66% of the population of the district of five or more years of age do not speak Portuguese, while those who do are mostly men, given their better integration in the social and school environment and in the labor market.

As far as the health network is concerned, the district has a rural hospital located in the district seat and in addition it has four health centers, namely the CS of Lapalisse Monapo, the CS of Cunle, the CS of Namigonha, the CS of Chicá, and three health posts namely the PS of Riane, the PS of Mecuasse and the PS of Ebar.

Data from 2009 indicate that the population per health centre is subdivided as follows: the rural hospital of Ribáuè: 20.530; the CS of Iapala Monapo: 36.625; the CS of Cunle: 21.133; the CS of Namigonha: 23.947; the CS of Chicá: 16.281; the PS of Riane: 31.323; the PS of Mecuasse: 13.774, the PS of Ebar: 6.285. The total number of technical personnel related to SSR consists of 17 nurses, 1 surgical technician and 3 doctors[2].

The epidemiological profile relevant for SSR features a high prevalence of STIs, especially syphilis, gonorrhea, candidiasis, which is more common in women and sistozimíase [?? maybe you mean: distomiasis?]. Data collected in the field show that the number of HIV positive cases among tested pregnant women is low. In recent years maternal mortality is declining. There were 13 maternal deaths in 2008 and 12 in 2009. Delays in getting to health units and labour dragging on sometimes for more than 2 days are mentioned as the main causes for this situation[3].

Regarding the school network, at present the district has four secondary schools located in the district seat, Iapala, Namigonha e Rinane. It should be noted that the schools in the last two localities opened in 2010[4].

Agriculture is the main economic activity of the district, it is practiced by hand on small family farms using the intercropping system on the basis of local varieties. Some families use traditional soil fertilizing methods, such as letting land lie fallow, the incorporation of plant stubbles, manure or ashes in the soil (MAE, 2005).

Generally speaking the region is characterized by the occurrence of three dominant agricultural production systems. The first corresponds to the vast low plateau dominated by intercropping of food crops, including cassava, maize, cowpea and pigeon pea as well as crops of the first rainy season, and by rice production in rain-fed river valleys, dambos[5] and lower parts of slopes. The second system is dominated by the production of sorghum, occasionally intercropped with maize and cowpea. Millet and peanut may appear in any intercropping. Cassava is the most important crop in terms of cultivated area. The third production system is dominated by cotton. The structure of agricultural production reflects the basis of the family economy, where 84% of farms are worked by three or more members of the family household (MAE, 2005).

IV.2 DISTRICT OF MOSSURIL

With a surface area of 3463 km², the district of Mossuril borders in the south on the district of Mongincual, in the east on the Indian Ocean, in the north on the district of Nacala – a – velha and in the west on the district of Monapo (MAE, 2005).

[2] Data provided by the SDSMAS of Ribáuè
[3] Data provided by the SDSMAS of Ribáuè
[4] Data provided by the SDSMAS of Ribáuè.
[5] Waterlogged zone in low lying savanah areas.

As far as its administrative division is concerned the district of Mossuril has three administrative posts, namely Mossuril Sede, Lunga and Matibane. Each of the administrative posts has one single locality, meaning that the district as a whole has three localities. Thus Mossuril-Sede has the locality of Namitatari, the administrative post of Lunga has the locality of Lunga Sede and finally the administrative post of Matibane has the locality of Matibane Sede.

FIGURE 3: LOCALIZATION OF THE DISTRICT OF MOSSURIL

PICTURE

According to the projected population data for 2010 the district of Mossuril has about 98.201 inhabitants and a population density of 28.4 inhabitants/km².

The population consists mostly of women, given that they number 49.357 while there are 48.844 men. This trend is observed in all age groups that have been taken into account.

According to the table showing the distribution of the district population by sex and age, 45.2% of the total of 98.201 inhabitants is of child-bearing age, 44.5% are youth and 3.3% are elderly. Therefore more than 95% of the population is under 65 years of age, meaning that one is dealing with a predominantly young and adult population.

Table 3: Population of the District of Mossuril per Age and Sex

Age	Men	Women	Total	
0 - 14	21,473	22,181	43,655	44.5
15 - 49	20,805	23,529	44,335	45.2
50 - 64	4,196	2,685	6,881	7.0
65+	2,370	961	3,331	3.3
Total	48,844 (49.7%)	49,357 (50.3%)	98,201	100%

Source: www.ine.gov.mz

This district is predominantly inhabited by matrilineal groups. According to data from MAE 2005, the dominant religion is Islam, practiced by the majority of the population. There are other beliefs and it is common practice that the representatives of religious dominations engage in coordination with district authorities in various activities of a social nature. The dominant mother tongue being Emakuwa, 85% of the population of the district of five or more years of age do not speak Portuguese, while those who do are mostly men, given their better integration in the social and school environment and in the labor market.

As far as the health network is concerned, the district of Mossuril has nine health units, the most important of which is the health center of Mossuril. The remaining eight units are spread over the administrative posts. At present the district as a whole has one female technician trained in SSR and two general practitioners. The epidemiological profile of the district is characterized by the large scale occurrence of malaria while the most frequent STIs are ggonorrhoea, syphilis, candidiasis, tricomoniasis and HIV and SIDA. To date the health centre referred to has tested 490 sick people, 34 of whom receive ambulatory treatment[6].

[6] Data provided by the SDSMAS of Mossuril.

The main economic activities are fishery and agriculture. The main crops in the agricultural sector are cassava and leguminous crops such as cowpea and peanut.

IV.3 DISTRICT OF NHAMATANDA

The district of Nhamatanda is located in the central-eastern part of the province of Sofala, about 100 km from the city of Beira. With a surface area of 3987 km² the district borders in the north on the district of Gorongosa, in the west on the district of Gondola (Manica), in the south on the district of Búzi and in the east on the district of Dondo.

As far as its administrative division is concerned the district of Nhamatanda has two administrative posts, namely Nhamatanda-Sede and Tica. These in turn are each subdivided in two localities, which means that the district has four localities. The administrative post of Nhamatanda-Sede has the localities Sede and Puazi, the administrative post of Tica has the locality Tica-Sede and Nhampoca.

FIGURE 4: LOCALIZATION OF THE DISTRICT OF NHAMATANDA

PICTURE

According to the projected population data for 2010 the district of Nhamatanda has about 254.828 inhabitants and a population density of 28.4 inhabitants/km². Combining these data with the total surface area of the district results in a population density of 52 inhabitants/km².

The population consists mostly of women, given that they number 131.742 while there are 123.086 men. This trend is observed in all age groups that have been taken into account.

According to the table showing the distribution of the district population by sex and age, 54.2% of the total of 254.828 inhabitants is of child-bearing age, 43% are youth and 2.8% are elderly. Therefore more than 97% of the population is under 65 years of age, meaning that one is dealing with a predominantly young and adult population.

Table 4: Population of the District of Nhamatanda per Age and Sex

Age	Men	Women	Total	
0 - 14	56,132	53,567	109,699	43
15 - 49	54,449	64,106	118,555	46.5
50 - 64	9,285	10,210	19,495	7.7
65+	3,220	3,859	7,079	2.8
Total	123,086 (48.3%)	131,742 (51.7%)	254,828	100%

Source: www.ine.gov.mz

The population of the district consists predominantly of the ethnic groups Shicena and Chindau. The languages of these groups are the most spoken and vary from region to region throughout the district. Shicena is predominant in the village seats Nhamatanda, Tica, Siluvo and Lamego.

The district is predominantly patrilineal and it has several traditional ceremonies namely one concerning birth called Mazuade, one around death called Pita kufa or pita madwade and one concerning the burning of the house called Pita moto. All these ceremonies involve the sex act. In addition to the above ceremonies there is the evocation of the dead called Nsembe, female initiation rites or rites on the eve of menstruation.

The district of Nhamatanda has 18 health units, 1 of which is the district hospital called Nhamatanda Rural Hospital, located in the village with the same name. The district also has 11 health centers, located in the localities of Cheadia, Tica, Lamego, Metuchira, Mutondo, Vinho, Nharuchonga, Mecuzi, Siluvo, Manguena and Macorrococho. The district has 6 health posts, namely the posts of Mbimbiri [in the locality of Macorrococho, Muda in the locality of Tica, Pedreira in the locality of Siluvo, Jone Segredo in the locality of Lamego and Jasse in the locality of Siluvo [and the 6th?].

The population distribution per health unit is as follows: the Nhamatanda Rural Hospital 44.353 inhabitants, Health Centre of Cheadia 9.538, Health Centre of Tica 30.797, Health Centre of Lamego 17.608, Health Centre of Metuchira 33.749, Health Centre of Mutondo 9.541, Health Centre of Vinho 9.157, Health Centre of Nharuchonga 8.741, Health Centre of Mecuzi 11.943, Health Centre of Siluvo 12.213, Health Centre of Manguena 8.320, Health Centre of Macorrococho 8.975, Health Post of Nhampoca 16.592 while the Health Posts of Mbimbiri, Muda, Pedreira, Jone Segredo and Jasse are included in the respective localities described above[7].

In addition to these health facilities there are 9 permanent vaccination posts set up by midwives and nurses in Mother and Child Health (MCH), namely: the village of Nhamatanda, Macorrococho, Lamego, Metuchira, Lomaco, Siluvo, Nharuchonga and Tica. The epidemiological profile of the district is characterized, among other diseases, by the occurrence of STIs such as gonorrhoea, syphilis and HIV / AIDS[8].

The district has a secondary school and each administrative post has an EPC, with the exception of the district seat which has three schools. Agriculture is the main economic activity of the district, it is practiced by hand on small family farms using the intercropping system on the basis of local varieties. Production is predominantly rain fed and not always successful, the risk of crop losses is high due to the soil's low storage capacity of moisture during the crop growing season.

IV.4 DISTRICT OF ZAVALA

The district of Zavala is located in the extreme south of the Province of Inhambane. In the north it borders on the district of Inharrime, in the south and the south-east on the district of Mandlakazi in the Province of Gaza and in the east it borders on the Indian Ocean.

FIGURE 5: LOCALIZATION OF THE DISTRICT OF ZAVALA

PICTURE

As far as its administrative division is concerned the district of Zavala has two administrative posts, namely: Quissico Sede and Zandamela. These in turn are each subdivided in two localities: the administrative post of Quissico Sede consisting of Quissico and Muane. The administrative post of Zandamela consists of Zandamela and Maculuva, which means that the district has four localities in all. The locality of Zandamela has twenty one settlements, the locality of Macoluva has twelve, Muani has eleven and Quissico has twenty settlements.

[7] Data provided by the SDSMAS of Nhamatanda.
[8] Idem.

According to the table showing the distribution of the district population by sex and age, the district has 191.610 inhabitants, 103.688 of whom are women, i.e. 541% and 254.828 are men, i.e. 45.9%. From the total population 41.9% is of child-bearing age, 46.5% are youth and 5.5% are elderly. Therefore 94% of the population is under 65 years of age, meaning that one is dealing with a predominantly young and adult population.

Table 4: Population of the District of Zavala per Age and Sex

Age	Men	Women	Total	
0 - 14	45,409	43,721	89,130	46.5
15 - 49	35,329	44,931	80,260	41.9
50 - 64	4,041	7,660	11,701	6.1
65+	3,143	7,376	10,519	5.5
Total	87,922 (45.9%)	103,688 (54.1%)	191,610	100%

Source: www.ine.gov.mz

This district is predominantly inhabited by patrilineal social groups and the predominant religion is Sião/Zione, practiced by the majority of the population. The district population is predominantly Chopi and the language mostly spoken is Chopi. Half of the population of the district aged 5 years and above has knowledge of Portuguese. The district is known culturally for having the Timbila dance, recognized since 2005 by UNESCO as World Cultural Heritage.

The district of Zavala has eleven health units, the largest of which is the Health Centre of Quissico. The remaining units are located in the administrative posts. At present the district has eighteen technicians trained in SSR. The epidemiological profile of the district is characterized by the occurrence of ITSs, such as leucorrhea, ggonorrhoea, syphilis, urethral flux, Kaposi's sarcoma, condyloma and HIV and SIDA[9].

Agriculture is the main economic activity of the district, especially the production of cassava. The district has a great potential for growing this crop. Agricultural activity is complemented by the animal husbandry, in particular cattle breeding. .

[9] Data obtained at the SDSMAS of Quissico.

V. MAIN RESULTS

This section presents the main findings from the fieldwork carried out in the four investigation sites, Ribáuè, Mossuril, Nhamatanda and Zavala. The results from Ribáuè and Mossuril were grouped given that these districts belong to the same province and for reasons explained in the sequel.

5.1 CHARACTERISTICS OF EDUCATION ABOUT SSR IN RIBÁUÈ AND MOSSURIL

The survey revealed that these districts present a remarkable cultural similarity despite the fact that the district of Ribáuè is located in the interior and the district of Mossuril along the coast. As far as SSR is concerned, this similarity particularly shows in the contents of the teachings provided by the community, the school and the health units to their members, students and service users. The cultural proximity of these two districts is also shown by the main stakeholders in the educational process with respect to SSR and by the moment these teachings are passed on.

Thus this section of the report seeks to visualize what is transmitted/taught about SSR, how and when it is transmitted, who are the main actors in this process, what the role of each stakeholder in the process is, the relationship between different learning environments/contexts, the education channels for girls and boys, the age/period when the learning cycle starts and the possible entry points for strengthening SSR in the community, the health facilities and the school. We will begin by presenting aspects related to the community, followed by those related to the health units and the school.

5.1.1. COMMUNITY

5.1.1.1 WHAT IS TRANSMITTED ABOUT SSR

As far as the learning context is concerned, the teachings about SSR passed on to boys and girls are different with respect to the content that is being taught but in terms of objective they complement one another because they constitute socialization moments about sexuality, a component in the building of feminine and masculine identity, of culturally acceptable social roles of what it is to be a man or woman in the adult life they enter into.

Within the above logic the process of transmitting these teachings about SSR takes place on the basis of gender differentiation. Similarly, the main stakeholders in the process as well as the specific moment in which these teachings are passed are adapted to the specifics of gender identity.

In terms of the situation sketched above Nampula turns out to have typical and specific teachings for women only and other ones for men only, which occur in quite different places and occasions. With the exception of the school where education is simultaneously transmitted to boys and girls, the transmission is differentiated in the community due to the specifics of being a woman or a man, and to the way people are expected to act on the basis of gender identity, which are to remain secret [I guess this is what is meant. Please check original, the Portuguese is gibberish]. While there are teaching both for men and women, they are to a large extent more aimed at women than at men.

The underlying logic of SSR education focusing more on women than on men in Ribáuè and Mossuril emanates from local perceptions according to which male education should be directed to highlight the stereotypes of masculinity which are thought of as innate, while women are thought of as requiring rigorous and even ritualized learning processes needed to construct their identity as a woman:

> *"From the moment the girl has her first menstruation, there are adult women who will teach her how to deal with menstruation and how she should behave, this ceremony is called Hekoma" (Traditional Midwife, Mossuril, Individual Interview).*

Most teachings directed at women focus on how to take care of the menstrual cycle, pregnancy, childbirth and on the way of being an living together at home with her husband. As far as the menstrual cycle is concerned it focuses on the cultural "dangers" of his phase both for men and for pregnant women, but there are also teachings about the hygiene to be taken care of during this period. Menstruation poses a clear danger for men because it may lead to them contracting diseases, such as for instance hernia. For women the situation is quite different. While for men menstruation is a source of contamination par excellence through impurities by means of sex and the consumption of food prepared by a menstruating woman, for women there are additional forms of contact with "dangerous" effects.

> *"When the girl has the first period we teach and give advice. First we ask her if she ever saw this blood before and if she says no, she was urinating and this blood appeared, the woman then asks her if anyone touched her genitals, if any one molested her, or if any man touched her vagina and she says no, it just came like that. Then we teach her that she should hide menstruation, that she cannot reveal it to anyone, we also teach her how to take care of the blood, how it is to use the cloth and tie it at the waist"* (Matron, Mossuril, Focus Group).

> *"During the menstrual cycle a woman should be clean and wear clothing called NAKAPA, clothes that are tied at the waist are a kind of sanitary towels"* (Guardian, Ribáuè, Focus Group).

> *"(...) a woman has to stop having sex because it can cause diseases in men, there is filth coming out an that may cause infections, she should not put salt in curry dishes, she can only put it on her own plate because it may cause a disease called KUHUNHO – hernia"* (Pupils, Ribáuè, Focus Group).

> *"When a woman is menstruating and has no one to salt the food, she should put 4 grains of salt in the corners of the stove, if she were to put salt directly on food the person eating it may cough a lot and if it is a man he may catch hernia"* (Matron, Mossuril, Focus Group).

In general, the dangers posed by the menstrual cycle for women are related to gestation, given that any direct or indirect contact with a menstruating woman can lead to a miscarriage. Direct contact would be through sharing of utensils used in drinking water or other beverages (including alcohol) while indirect contact would be through a husband's sexual intercourse with a menstruating woman and subsequently with his pregnant wife.

> *"A woman in the first stage of pregnancy is taught not to eat or drink water at her neighbour because it can cause a miscarriage. A menstruating woman should not give water to a pregnant woman because it can cause a miscarriage. If this happens they seek a godmother who comes to treat the pregnant woman gives treatment and the danger passes. A menstruating woman should not have sex"* (Traditional Chief, Ribáuè, individual interview).

> *"During the menstrual cycle, a woman cannot have sex because the man runs the risk of contracting hernia"* (Traditional Midwife, Mossuril, Individual Interview).

Here in particular it is noted that menstruation is "dangerous" both for men and women and most individual interviews and focus groups keep referring to this teaching as one of the fundamental and structuring aspects of education about SSR.

Although in Nampula teachings about pregnancy differ in the community, the school and the health unit, there are some points of convergence, as shown in the sequel.

The community teaches that if a woman is pregnant, her husband should avoid having sex with other women, especially if they are menstruating. The health unit also mentions this restriction and motivates it with the need to prevent various infections. In the community the explanation is related to the danger of abortion that may be caused by such contact and to the fact that the baby may be born with "filth".

Other teachings during pregnancy that are common in the community and in the health units are related to the need for proper care, especially with respect to the diversification of food, the regulation of physical efforts by controlling travel distances and to loads that may be carried in the course of the gestation period.

> *"The mother and grandmother explain how the pregnant woman should take care of herself, she should not do heavy work, not sleep with a man other than her husband while pregnant"* (Guardian, Mossuril, Individual Interview).
>
> *"When a woman is pregnant I teach her to prepare enriched porridge and to eat matapa in order to strengthen her body during pregnancy. I also explain that from the 6/7 month onwards, she should engage in heavy work such as fetching water or firewood, or weeding"* (Traditional Midwife, Mossuril, Individual Interview).

With respect to pregnancy the community, in addition to stressing being careful with food, due to the need for diversification of the diet as a way to ensure the healthy growth of the baby (for instance fruits, vegetables with groundnut), its teachings seek to restrict the consumption of certain foods which in the local perception might contribute to congenital malformation and the occurrence of abortions [please check original, the Portuguese is unclear]. In Ribáuè in particular this concerns the consumption of monkey meat, fish, turtle, among other things. It is believed that eating monkey meat may lead to the baby being born with monkey features. The tortoise, due to its slow movements, may cause "laziness" in the baby and to it not moving properly during the gestation period while fish by the way it manifests itself, characterized by successive movements, may pass on its "instability" to the baby that is growing, something which may lead to a miscarriage or to notable physical disabilities. According to the interviewees:

> *"Pregnant women should not eat monkey meat because otherwise the baby will have monkey features, or owls and bats because it can have features similar to these animals"* (Pupil Ribáuè, individual interview).
>
> *"They are taught not to use turtle because otherwise childbirth will take a long time and as far as rats are concerned, that is tricky because when it is born it may not have a good head, it is to be avoided"* (Guardians, Ribáuè, Focus Group).
>
> *"During pregnancy, women should not eat a fish called "ximpulopulo" and if they do, they may be pregnant for 3 years"* (Traditional Midwife, Mossuril, Individual Interview).

Care related to pregnancy is extended to sexual relations, but also on a recurring basis the woman is taught where she should or should not be inside her house and the teachings for the man are related to the day of childbirth.

> *"A woman should not stand in the doorway because it will take the baby a long time to be born, the child will stay in the doorway where the mother was when she was pregnant"* (Godfathers and Godmothers of the rites, Ribáuè, Focus Group).

> *"When a woman is pregnant can not stop or sit on the doorstep because she will have problems with pains on the day of delivery and she also should not eat sugar cane and pineapple"* (Guardian, Mossuril, Focus Group).

> *"According to the tradition she cannot sit on the doorstep on the day of childbirth because the child will be there but not come out; when the day of childbirth arrives the man should not put on his belt, or close the buttons of his shirt, or close the door of the house because when that happens he is blocking the ways for the child to be born"* (Guardians, Ribáuè, Focus Group).

With respect to the way of being and living in the home and the relationship with her husband, the woman is taught in the initiation rites what to do before, during and after having sex, because in the local perception this is one of the key aspects in managing matrimony.

> *"In the initiation rites it is taught how to put the man's penis in the vagina, how to pull the labia so as to not only have a head, it has to have ears as well in order to look pretty, they teach her to clean the man after having sex. They teach her to sue IPITXI, a substance to put in the "matunas" [vagina?] so that it is not too wet. The substance is also put on the penis before having intercourse"* (Guardians, Ribáuè, Focus Group).

> *"You can teach a girl to do Othuna (vaginal stretching) from 8 years of age onwards, usually when a woman marries she stretches it in front of her husband in order to excite and encourage him to have sex. The woman can also do this when she has got nothing to do, just to be ready for when she sleeps with the husband"* (Guardian, Mossuril, Group Interview).

> *"(...) they also teach her to have a clean cloth, which should be under the pillow and that is used after having sex with her husband to clean him, this cloth should not be left in the sight of others. After having sex the woman should clean the penis of the husband very well and carefully with that cloth, she cannot have sex and turn around, no, she also has to use that cloth to clean herself, so that she does not soil the bed. Women are taught to be active when they have sex with their husband, how to kiss him, they have to respect the husband's family and always have lunch ready for her husband"* (Matron, Mossuril, Individual Interview).

> *"(...) In the initiation rites she is taught to dance for her husband, how to live with her husband, the special treatment to be given by a woman after having sex, namely cleaning her husband's penis and having water for bathing, do body massage"* (Godmother of initiation rites, Ribáuè, Individual Interview).

Teachings concerning the period after childbirth, like those about other moments of life, revolve around the prohibition, among other things, of having sex. Although the period during which the woman who gave birth can not have sex varies according to respondents, it is commonly assumed that this prohibition lasts until the baby starts walking in order to avoid possible diseases, and this may constitute a traditional form of family planning.

> *"You can not have sex before the child is 8-9 months old, otherwise it will catch a disease called MAVUKA – the child becomes weak and thin and it cries a lot"* (Guardian, Ribáuè, Individual Interview).

> *"When a woman has a baby she should not sleep with her husband during one whole year because otherwise the baby will not grow well"* (Matron, Mossuril, Individual Interview).

With respect to abortion one noted particularly in Ribáuè the reticence of interviewees to comment on the subject, indicating that people are not very open to talk about this. However, in Mossuril the experience was different and the discourse revolves around prohibitions and the state of impurity in which the woman finds herself.

> *"After an abortion she should not do heavy work and she can't sleep with her husband for a period of three months"* (Traditional Midwife, Mossuril, Individual Interview).

> *"When a woman has an abortion the adult women explain to her what happened, they tell her not to eat salt and chili and that she should not sleep with her husband. After three months they can establish whether the blood that appeared really was a miscarriage or menstruation during pregnancy"* (Matron, Mossuril, Group Interview).

As far as the boys are concerned, teachings are basically about their being and living in the period immediately after reaching "adulthood", that is, after circumcision. Both in Mossuril as well as in Ribáuè, circumcision is a prerequisite that symbolizes the transition to adulthood. In the course of the circumcision boys also are taught about their behavior in the period immediately following the ritual. These teachings focus primarily on the respect for adults and the responsibility that the boy is going to have as a result of this new phase. This education teaches little or nothing about issues related to SSR, the perception being that masculinity is not something to be taught, that it is natural, contrary to happens with women who have to learn and to be taught all about being a woman.

> *"In the initiation rites they teach the boys that they are grown, that they should refrain from childish things, when their father or mother die they may bury them, they are taught to have respect. According to the tradition he who has not been circumcised may not see a dead person or participate in the ceremony, he may not see the grave, so doing the rites means growth"* (Godfather, Mossuril Group Interview).

> *"They are taught to respect people, their father or anyone, they should not leave without doing their homework, they may not insult, they can't enter their mother's room just like that, or their mother's bathroom, even if it is the only bathroom in the house they can't enter"* (Guardian, Mossuril, Group Interview).

> *"The person is told that he is grown, he cannot insult people in the street, he may not under his mother's bed, he may not enter his mother's room without asking permission"* (Godfather, Mossuril Group Interview).

5.1.1.2 MECHANISMS CONCERNING TEACHING ABOUT SSR

These teachings are transmitted in line with various practices, ranging from advice in initiation rites at home by "elderly people", visits of health units and lectures and educational theater.

The timing of passing on these teachings to girls in the community coincides with the first menstruation and they continue through subsequent stages passed through by women in the course of their lives, in particular marriage, pregnancy and childbirth. For women there is a common denominator in the form of the first period while the timing for men is variable.

Although it is clear when this period begins in the case of women and that this varies in the case of men, what these two moments in which these teachings are transmitted have in common is that they coincide with the beginning of the initiation rites and represent a component that structures the social construction process of the male and female social roles and identities.

> *"When they have their first menstruation the girls are subjected to traditional education. The boys from 7/8 years onwards receive traditional education and begin with the initiation rites"* (Teacher, Ribáuè, Individual Interview).

> *"In the initiation rites the girl is taught about how to care for the menstruation and that she ought to respect the elderly"* (Female Pupil, Mossuril, Focus Group).

5.1.1.3 MAIN STAKEHOLDERS IN EDUCATION ABOUT SSR

The main stakeholders in this educational process vary depending on the context and the teachings. In the community dominate the godfathers, the godmothers and initiation rites matrons, the Community Health Workers (ACSs), religious leaders, practitioners of traditional medicine, traditional midwives and the "elderly", while the fathers and mothers play a secondary role. Standing out in Mossuril in particular, in addition to the godfathers, are the people responsible for carrying out the initiation rites for boys.

5.1.1.4 ROLE OF THE STAKEHOLDERS

Although the content of the transmitted education is different, the role of each of these stakeholders mentioned in the previous paragraph shows great similarities from the point of view of the purpose that each seeks to achieve in the executing his educational task.

The godfathers and godmothers of initiation rites educate young men and women upon the request of the parents who are interested in educating their sons and daughters, so they are responsible for advising the youth being initiated. An important fact to consider is that this advice extends in the course of one's life, which means that the godfather and godmother of the initiation rites may be called upon at future moments in the lives of their "initiated youths". The matrons are the social actors responsible for carrying out the initiation rites for girls. In general, according to data collected in interviews in Ribáuè, in many cases the matron is also practitioner of traditional medicine (PMT). In this district it is in this particular aspect (the double social roles of Matron and PMT) where resides the difference between the godmother and the matron of the initiation rites.

As far as the boys are concerned, despite the fact that the godfathers of the initiation rites in Mossuril are responsible for executing these rites, it is the elderly men who know what is to be transmitted to the boys. The godfathers have the role of caring for the youngsters to be initiated during the period when they remain in the site where the rites take place and this care includes the preparation of food and hygienic precautions after circumcision.

The vast majority of the elderly are responsible for the education of the girls upon the request of their mothers, as evidenced by the statements below:

> *"When the moment to offer advice arrives, when the mother has to give advice, she invites the grandmother, the elderly from the family, they are the experts who offer advice on how to take care of her husband, her period, precautions with respect to pregnancy and childbirth. The moment is when they have their first period and they do the initiation rites, the first advice is offered at home by her*

grandmother, or a group of elderly ladies giving the girl advice on what to do after pregnancy, childbirth and abortion" (Female Pupil, Ribáuè, Focus Group).

"On women's issues it is the grandmothers who teach, and for the boys it is the uncles from their mother's side. The husband's family does not enter into the education, but this does not change the responsibility of the man inside the house" (Guardians, Ribáuè, Focus Group).

"When the menstruation appears the woman may already be a mother and from that moment onwards an elderly woman, who may or may not be family teaches you and gives all the information about the care to be taken during the menstruation period" (Traditional Midwife, Mossuril, Individual Interview).

In addition to being responsible for carrying out initiation rites the practitioners of traditional medicine provide specific services during pregnancy, childbirth and the period after childbirth, i.e. at the community level they play a significant role and individuals appeal to them for health care in general and for sexual and reproductive health in particular. According to data collected in the field:

"(...) I give medicine for the bath of the newborn, as dictated by tradition. I massage women who have just given birth. For complicated deliveries I look for medicine to give the woman in order to facilitate childbirth. I can tell whether the baby moves or not and administer medicine so that it moves, I deal with evil spirits that do not let pregnancies develop well. During childbirth I offer assistance and tie a kerchief around the belly that helps the baby to descend. After childbirth I do massages, I bath her, I put a sanitary towel and give her something to eat, normally pounded rice or millet flour mixed with water so that she does not die from hunger and to increase the milk for the baby" (Traditional Health Practitioner and Matron of the rites, Ribáuè, Individual Interview).

"It's a medicine to be taken that helps her to get pregnant, after preparation it has to be taken immediately, first the Nkulucana (practitioner of traditional medicine – herbs expert) and then the patient. After that the woman can have sex which will enable her to get pregnant" (Practitioner of Traditional Medicine – Herbs Expert, Mossuril, Individual Interview).

Religious leaders have a role in education about SSR, especially in Mossuril. In this district more than 70% of the population is Muslim, a fact that is to be understood in order to understand the role of this religion in education about SSR. Catholicism, despite having very few believers as compared to Islam, also has an important role in educating young people on SSH. In Mossuril the active role of the church with respect to this issue results from the fact that it recognizes the importance of initiation rites in the construction of the identity of men and women.

"In the mosque we teach the man that he cannot have multiple partners, he cannot come to the mosque while he is impure, (just had sex, is drunk or had a fight with someone). Women are taught that they cannot enter the mosque while they have their period, and after the wedding they have to take care of their husband. We also teach the man that he cannot have sex with other women while being father of a small baby because it is bad for the baby's health" (Muslim Religious Leader, Mossuril, Individual Interview).

"Here at our church we also do initiation rites as a process of incorporating other cultures [inculturar?] into the religion. The men have their own cultural principles and the church should not be an obstacle, the initiation rites also need to be evangelized. We have counselors who, when young people turn 17, offer advice based on the Gospel of Christ ... these counselors are trained to offer advise about good

> *moral conduct. We also ask Health to send a nurse who can do the circumcision. When the time to marry arrives we also offer advice on the proper married life"* (Catholic Religious Leader, Mossuril, Group Interview).

The Community Health Workers[10] (ACSs) are responsible for education and promotion of health in the community. Apart from the traditional midwives it was not possible to meet ACSs in Mossuril.

> *"The ACSs get the community together and raise awareness that women should care for their personal hygiene"* (Traditional Midwife, Ribáuè, Individual Interview).

Traditional midwives, in addition to assisting at childbirth, also provide care during pregnancy and the period after the baby's birth.

> *"Regarding pregnancy I urge them to give birth in the hospital so that the pregnancy is well monitored. After child birth I control the weight and teach how to feed the child. We teach children not to become pregnant prematurely. If a girl is 15 we explain that it will be difficult to give birth, she has to wait until she is 18 or 20. With respect to abortion we tell them that we midwives do not have all necessary working tools, a person may have HIV/AIDS and we cannot assist them. We can't help people with malaria. We were trained to make mothers aware so that they go to the hospital, there are mothers who cannot go alone without being taught to do so. About childbirth we teach that delivering a baby is difficult, many things can go wrong, we teach them that sometimes they need to be operated upon. I cannot always offer assistance, when a woman has a lack of water she needs an injection or a serum and we don't have that. So it's hard to assist childbirths in the community"* (Traditional Midwife, Ribáuè, Individual Interview).

> *"I assist mainly childbirths of those women who cannot go to the hospital. I send girls who become pregnant prematurely, at 15 or 16, to the hospital because they are still very young, I send adult women who become pregnant also to the hospital, especially those with anemia have to go to hospital. I also teach women to make enriched porridge in order to strengthen their body during pregnancy and I advise them not to do heavy work from the seventh month onwards"* (Traditional Midwife, Mossuril, Individual Interview).

5.1.1.5 RELATIONSHIP BETWEEN THE COMMUNITY, THE SCHOOL AND HEALTH

The relationship between the three levels involved in education, namely the community, the school and health, although not consistent and structured, offers meeting places, especially the relationship between the health sector and the community with respect to the care of pregnancies. The relationship between the community and the school is weak, there is no dialogue about SSR education between these two levels.

5.1.1.6 AVAILABLE HEALTH SERVICES

Health services available in the community are: education and promotion of health by means of counselling corners, traditional midwives, practitioners of traditional medicine, counselling by ACSs and SSR activists.

[10] The Community Health Workers are people from the community responsible for mobilizing and sensitizing the community. In some cases they receive basic training in preventive medicine at primary level (health education and promotion). In some cases traditional midwives may also be ACSs.

5.1.1.7 ROLE OF THE PARENTS IN THE EDUCATION ABOUT SSR

Concerning parents' demands for information about lessons on SSR learned in school, they generally seek very little information about what their children learn in school. In addition parents seek to know little about the knowledge on SSR acquired by their children in the health unit. These facts may reveal that sexuality is a subject little discussed between parents and children.

5.1.1.8 KNOWLEDGE ABOUT SSR TRANSMITTED AMONG YOUTH

Youth activities out of school in Ribáuè and Mossuril are limited to sports, watching movies and soap operas, and hanging out with friends. In Mossuril youngsters go to the to disco at weekends and they engage in petty trade in the trade fair which takes place on Saturdays in the district seat.

Although young people do acquire the teachings passed on by the elderly through the mechanisms referred to above, they talk among themselves and make their own choices. A clear example of this is offered by the multiple and co-existing relationships in which young people are involved, contrary to the teachings of their elders. It was common to hear from boys that their conversations revolve around "*amuelelar*"[11], meaning to enjoy, loving, being in the mood to have sex with a girl and the choice of the "best partners" and "best girlfriends". The conversations of girls focus on the initiation of sexual activity, mainly encouraged by the "more experienced" girls.

With regard to their behavior and the conflict with elders, young people argue that the present times are different from those lived by their parents and that the movies and soap operas they watch cannot be considered as determining factors for the conduct of young people because according to the statement below:

> *"A youth can watch these films and soaps without being influenced by them, it depends on the individual"* (Pupil, Mossuril, Focus Group).

The recurrent discourse among boys from Mossuril in particular reveals in addition to premature sexual relationships by girls, that they have multiple partners sometimes motivated by material gain. This reality puts some pressure on the boys to enter the informal labour market given that they have to satisfy some material wishes of their partners or run the risk of losing them.

> *"Girls nowadays start dating very early because of money, a girl can have her real boyfriend and another one who sustains her"* (Pupil, Mossuril, Focus Group).

> *"Girls nowadays are fond of money and just flirt with boys who support them so you have to do something to fetch money so you can buy her something now and then"* (Pupil, Mossuril, Focus Group).

This discourse shows that young people engage in sexual networks early on and these multiple and concurrent partnerships illustrate in part how the dynamics of sexuality among young people in this district plays out.

5.1.1.9 ROLE OF NGOS

The role of NGOs is limited, because at the level of the two districts studied there are very few NGOs working on SSR issues. In the district of Ribáuè there are 3 NGOs active but they do not concentrate on SSR. PSI

[11] A word borrowed from the Macua language, subsequently adapted.

intervenes mainly through the distribution of condoms, the Community Health Association Salama is active in community education aimed at malaria and sanitation.

5.1.1.10 POSSIBLE ENTRY CHANNELS FOR REINFORCING SSR

With respect to a possible entry point for strengthening SSR education, is has become clear that the weak point is the limited dialogue between parents and children about sexuality. The strong point is that there are the godfathers, godmothers, matrons, ACSs and activists who have strong links with the community. Building on these players we can introduce new issues in the approach of SSR, taking into account the principles of gender equality and new knowledge about SSR that is more in keeping with the cultural reality referred to.

5.1.2 SCHOOL

5.1.2.1 WHAT IS TRANSMITTED

Generally speaking the contents transmitted at school focus on delaying the first sexual activity until reaching 18 years of age, abstinence, unwanted pregnancies and issues associated with HIV and AIDS.

> *"Condom use, not engaging in sexual activity as soon as possible, abstinence and saying no to unwanted pregnancies, counseling of students, taking precautions and doing the test. In our teachings we urge students not to ignore the information, the current situation with respect to HIV, we guide the children to avoid unwanted pregnancies and premature sex"* (Head of Education, Ribáuè, Individual Interview).

> *"Safe sex is one of the contents, precautions with respect to pregnancy is another, one cannot assume that everyone is prepared. We talk about STIs"* (Teacher, Mossuril, Individual Interview).

5.1.2.2 MECHANISMS CONCERNING TEACHING ABOUT SSR

Within this learning context the SSR teachings have greater visibility from secondary education onwards although there is a Basic Package at primary education level. The greater visibility of SSR education at secondary education level is due to the fact that on the one hand certain curricula already include part of the issues related to SSR and, on the other hand, because specific programs for young people are implemented from this level onwards. Generally speaking what is transmitted concerns the following areas: premature pregnancy, condom use, abstinence and STIs and HIV.

The methods used for the transmission of SSR education at school are lectures, theater and sports tournaments. The moments proper for offering this education are varied, but in general they boil down to passing on information before the start of classes, activities in the classroom or to individual contacts in classes and during sports activities. Although SSR issues are part of the cross-cutting themes of the education curriculum, its implementation depends more on the initiative of individual teachers or on teachers who happened to receive training about SSR.

5.1.2.3 MAIN STAKEHOLDERS

The main stakeholders in the schools are the teachers and activists of the SSR programmes, with distinct roles and responsibilities. According to the results of the field research:

> *"The lectures are given by teams of the District Service Youth Education and Technology, school health professionals, school teachers and activists responsible for SSR"* (Head of Education, Ribáuè, Individual Interview).

5.1.2.4 ROLE OF THE STAKEHOLDERS

Although each stakeholder has his prior level of clearly defined performance the roles of these actors have many similarities and affinities and therefore one does not encounter significant differences. Added to the teachers' primary educational role of teaching is the responsibility for the education and promotion of sexual and reproductive health. This responsibility is shared by student activists whose activities concern their fellow pupils.

The role of student activists is to raise awareness among their fellow students so that these adopt preventive measures, be these related to unwanted pregnancies or to HIV and AIDS. These actions are executed using various techniques such as drama and sports. The activists are students who volunteer and who receive training under the responsibility of the Provincial Directorate of Education. In general the activities are conducted in the school and they may occur in breaks or in the hours reserved for class meetings or during gatherings of students in coordination with the pedagogical sector. In addition to having a coordinator among them, the student activists are under the leadership of a teacher activist who also has received training about SSR issues as well. According to the interviews:

> *"The teachers in school play the role of educators and the activists are responsible for the dissemination of information, they are obliged to disseminate information which is clear about the dangers of SSR. Teachers have these responsibilities because students need to study"* (Head of Education, Ribáuè, Individual Interview).

> *"The role of teachers is an active one because previously in educational programs one only talked in biology, but now the subject is talked about in all programmes, all disciplines"* (Head of Education, Ribáuè, Individual Interview).

> *"The role of students is to pass on information to colleagues, brothers and other family members, to share what they learn in class or at school"* (Student, Mossuril, Focus Group).

At school there is no differentiation with respect to the channels and moments of education (just like in the community), because at school education is offered simultaneously and cross-cutting themes dominate without distinction in terms of focus [and this?].

5.1.2.5 RELATIONSHIP BETWEEN THE SCHOOL, THE COMMUNITY AND HEALTH

As far as the relationship between school and community is concerned, this has been evolving gradually either through the school boards, either through dialogue with local authorities. One of the highlights of this relationship concerns the coordination that exists to determine the period when the initiation rites take place and the period of the school exams. As shown by the results of the interviews:

> *"(...) at the time we did not know the school calendar, the initiation rites took place on the eve of exams, there was an agreement with the parents to find another period and now they take place in December / January after the exam"* (Head of Education, Ribáuè, Individual Interview).

Also part of the relationship between school and community is the effort to integrate the knowledge of the two universes, albeit in inchoate form. What one still finds is the existence of a persistent rupture between education and the other universe. This rupture is due to the fact that traditional education cannot find the continuity necessary for the level of formal education although the latter, being one of the players responsible for secondary socialization, at times complements the teachings offered by the community.

> *"(...) we don't talk in isolation, we capitalize on what students bring to school from the community. They usually bring information about the initiation rites or other information from the community, here almost all boys have already gone through initiation rites, for the girls it is different because it depends on their first period. Until the 7th Class one talks about the positive and negative aspects of initiation rites in school"* (Teacher, Ribáuè, Individual Interview).

With respect to the relationship between the school and the health services the gap seems to be even greater. The distance between these two universes is clear, and judging by the lack of specific actions from both sides aimed at working together, these sectors lead us to the conclusion that if they do not establish a concrete relationship this void may last longer.

5.1.2.6 AVAILABLE HEALTH SERVICES

Health services available to schools in the province of Nampula are the education and promotion of health through the Geração Biz Programme and other actions within the context of school health and sanitation.

5.1.2.7 THE ROLE OF THE PARENTS IN EDUCATION ABOUT SSR

The data collected by means of individual interviews and focus groups reveal that parents do not use the existing opportunities for dialogue with the school, although there are School Councils. On the other hand it appears that parents do not try to find out what their children learn in school.

5.1.2.8 KNOWLEDGE ABOUT SSR TRANSMITTED AMONG YOUTH

What youth learn in school or teach one another is the result of the SSR training programmes that exist at secondary school level in the education sector, and it is largely confined to condom use, STIs, HIV and AIDS, the prevention of premature pregnancies, among other things.

5.1.2.9 ROLE OF THE NGOS

At school level as well as in the community, there is a poor or almost no involvement of NGOs in the area of SSR.

5.1.3 HEALTH UNIT

5.1.3.1 WHAT IS TRANSMITTED

Within the learning context the lessons on SSR tend to be more focused on women and there continues to be little emphasis on men. This is reinforced by the fact that the issues at hand are the prime responsibility of nurses in Mother and Child Health (SMI).

> *"SSR of women is provided for in the Antenatal Consultations (CPN), Family Planning (PF),*

gynecology, high-risk obstetric consultations - ARO. There are no specific services for men, they go to external consultations and normal examinations" (Chief Doctor, Ribáuè, Individual Interview).

"Here we do CPN and postnatal consultations, we distribute condoms, assist childbirths but our space is very small so we can not provide many services" (SMI Nurse, Mossuril, Individual Interview).

5.1.3.2 MECHANISMS OF EDUCATION ABOUT SSR

At the level of the educational sphere, the period of teaching is confined to the CPN, mobile teams and the periodic health education campaigns in the communities. Still, the teachings are limited to family planning, institutional childbirth and condom use. In general the teachings fit into the perspective of safe motherhood and birth control and reducing the risk of HIV infection.

"We teach how to do family planning and not to conceive early because of the problems that may arise, to come earlier for treatment in case of ITS, the dangers of pregnancies without adequate space, we also demonstrate the use of condoms and we talk about contraceptives in general" (SMI Nurse, Ribáuè, Individual Interview).

This education is basically using a clinical approach, based upon medical consultation.

"For women we do antenatal consultations and family planning. The men accompany the women and some benefit when the women do laboratory tests. There are no specific services for men, they go to the normal consultation, use the Album series, lectures and other material. In the lectures we talk about STIs, condom use, HIV, institutional childbirths, PF, ARO consultation, but try to talk about caesarean section and they don't come back to the health unit" (Chief Doctor, Ribáuè).

5.1.3.3 MAIN STAKEHOLDERS

The main stakeholders in the educational process are the SMI nurses and doctors. The SMI nurses are responsible for antenatal consultations and family planning, while the doctors are responsible for other consultations, such as High Risk Obstetrics - ARO.

5.1.3.4 RELATIONSHIP BETWEEN HEALTH, COMMUNITY AND SCHOOL

The relationship between Health and community is more visible than the relationship between Health and school.

Generally speaking with the community,

"There is a link, which I have seen for example in the PTV, they pose many questions and try to understand what things means, to acquire some knowledge" (SMI Nurse, Ribáuè, Individual Interview).

"They work with the ACSs, many women already have their reference guides when they come to the hospital. As far as teachings of initiation rites are concerned, that is difficult" (SMI Nurse, Ribáuè, Individual Interview).

"Whenever we do activities in the communities we introduce ourselves to them, mobile teams are always working with the collaboration of the traditional chiefs" (Chief Doctor, Ribáuè, Individual Interview).

"We have a partnership with the community through the traditional midwives who refer pregnant women to the hospital. If you walk around here, you will find a midwife who works with us" (Doctor, Mossuril, Individual Interview).

5.1.3.5 AVAILABLE HEALTH SERVICES

As far as available health services are concerned the focus is on the CPN and on normal consultations. In Mossuril saw the recent start of the SAAJ, a SSR service targeting primarily adolescents and youth.

"(*...) CPN has great affluence [influence?], but institutional childbirths have diminished. Many births occur outside the health units, people travel long distances to deliver babies in health units (...) there are many emergency caesarean sections, on average there are 6 to 7 caesarean sections per week on women from remote areas but sometimes the number increases (...) There is no shortage of contraceptives so far, there is little demand for condoms"* (Chief Doctor, Ribáuè, Individual Interview).

"In January we started with the SAAJ service and so far I attended about 8 young people, most of them girls, they basically come to ask questions and get condoms" (Nurse, Mossuril, Individual Interview).

5.2 CHARACTERISTICS OF EDUCATION ABOUT SSR IN NHAMATANDA

5.2.1 COMMUNITY

5.2.1.1 WHAT IS TRANSMITTED

The investigation found that in Nhamatanda the transmission of teachings about SSR is based on the differentiation of gender, which is to say that there are teachings exclusively for women and other ones for men. Among the various aspects covered in education the emphasis is on the need to start late having sex, the menstrual cycle, care related to pregnancy, childbirth, care related to abortion and the attention a woman should pay to her body, including the elongation of the minor labia.

The Nhamatanda education in general is more directed towards women than towards men. Women are taught about hygiene, especially during menstruation, and to maintain the description of the state they are in [original unintelligible]. As for sexual activity is concerned, the teachings focus on techniques that women can use to pleas the man, such as using beads on the hips, the movements during the sex act as well as how to do "mathuna" or "matindje" (stretching minor labia) for a period of 2 to 3 months in order to achieve the size that is considered ideal.

Beads on a woman's hips are seen as a supplement that highlights the feminine composure during the moments leading up to sex. For example during the dancing at these moments the beads produce a sound that is considered to be inspiring, motivating and provoking the male erection. The stretching of the labia is seen as a key element in the conquest of the man and an important feature that prevents him from looking for other sexual relationships.

Thus the elongation of the labia has a double function, an aesthetic and an "ethical" one. Aesthetic because it is part of what is considered to be the perfect woman, ethical because is part of the mechanisms that may contribute to regulate and control male sexuality.

"... We teach them to do mathuna in their spare time, as a mechanism to attract the man. Mathuna is done with heated cooking that is subsequently cooled down, or with cream. The cream is put into the

> *bottle and then the girl takes the cream and scrub her palm and she will stretch the labia during a period of up to three months until the labia are big and are in the position of "mathuna" ... "* (Godmother of initiation rites, Nhamatanda, Group Interview).

With regard to pregnancy knowledge is transmitted about the proper clothing during this period, clothing that allows for a healthy pregnancy. This education also includes prohibitions and permissions associated with for example having sex, in particular after the seventh month, and with doing heavy work. The prohibitions also include the consumption of "stuff" (yellow sand) to avoid nausea. The post-partum period is marked by permissions and prohibitions which include, among other things, not having sex, care such as massage with hot water done by an elderly woman and the breast feeding of the baby.

In the perception of the community abortion is part of the practices considered reprehensible, therefore the woman is taught to never do it and in case it does occur one is recommended to do the "traditional" treatment of "pitakufa" or "pitamadwade", i.e. the purification of the woman through the sex act. After the abortion there is also a ban on having sex until the woman is cured of the possible problems that may occur after an abortion.

The education of men focuses on the construction of masculinity, which includes procreation in order to continue the family name, sustaining the family, conquering women and testing his virility through sexual intercourse and/or masturbation.

5.2.1.2 MECHANISMS OF EDUCATION ABOUT SSR

Girls are educated about SSR through the initiation rites, which constitute a privileged moment for the transmission of teachings. While certain segments of the population of Nhamatanda continue this practice, in general it has become less frequent. One of the reasons for this decrease is to the fact that nowadays there are families who do not consider this moment as an indispensable condition for the passage to adulthood. There are for example women who learn from the elderly or from friends and who stretch the labia when they think they are ready for marriage and reproduction without necessarily having gone through initiation rites.

For boys the time of education is less rigorous, i.e. there is no specific occasion. Contrary to the girls where the moment is identified with the onset of the first menstrual cycle, the moment may consist in "informal" conversations, i.e. it may occur sporadically. In addition, circumcision is not a common practice in Nhamatanda and does not constitute a mechanism for the identification of a man's masculinity.

Other forms of passing on teachings about SSR are the traditional ceremonies performed by traditional healers, elders, religious and community leaders, parents and guardians. The church is another mechanism to transmit knowledge and usually it takes place through prayer and advice on the correct behavior.

Education about SSR takes place during puberty and adolescence. In general it targets the age group of 11 to 16 years both for boys and for girls. During the other phases of life knowledge is also transmitted but not systematically, since it is assumed that people already have a grip on these issues and control over their sexuality.

> *"... The girl enters the initiation rites with 11, 12 or 13 years. But the most widely used criterion is the signal that the girl's body gives ..."* (Godmother of initiation rites, Nhamatanda, Individual Interview).

> *"... These kinds of teachings transmitted in the community are passed on in almost all stages of life, but that the message varies from age to age, every generation has a specific message ..."* (Guardian, Nhamatanda, Individual Interview).

5.2.1.3 MAIN STAKEHOLDERS IN EDUCATION ABOUT SSR

The main stakeholders involved in the transmission of knowledge about sexual and reproductive health in Nhamatanda are mainly the grandfathers and/or paternal uncles for the boys and the grandmothers and paternal aunts for the girls. There are also other complementary players in the educational process such as: the elderly, community leaders, traditional healers, traditional midwives, the godmothers of the initiation rites and the mothers and fathers of the boys and girls. The role of the parents is sporadic and secondary, sometimes they may offer advice to the children but it varies from family to family.

5.2.1.4 ROLE OF THE STAKEHOLDERS

The grandfathers, grandmothers, paternal uncles and aunts have a central and indispensable role in this process and at the same time they are responsible for talking to the grandsons and granddaughters about the stage of life that they are approaching. After the onset of menstruation the grandfathers, grandmothers, paternal uncles and aunts teach about the precautions that the girl should take with menstruation. They also test the virginity of their granddaughters, using traditional medicines, they give advice to the parents about the ideal time for the wedding of the granddaughter and they participate in suggesting a possible husband.

> *"... When a mother sees that her daughter is almost an adolescent she warns her husband and then the two decide to take the girl to the home of her grandparents or to the initiation rites in order to learn about the attitudes and behavior that she should have ..."* (Female pupil, Nhamatanda, Individual Interview).

The boys' education also is the responsibility of the elderly. Testing manhood is not a common practice undertaken by those responsible for SRR education. But when it does occur, even sporadically, it is characterized by informal conversations where one seeks to know if the boy has had wet dreams, already likes women and whether he has had sex already. If not, the boy is encouraged towards attitudes and conduct that guide him in having sex. The education of women concentrates more on how to sexually please the man and learn to "manipulate" the multiplicity of social roles that await them as woman, mother and wife.

Community leaders and practitioners of traditional medicine are responsible for resolving problems related to SSR. In the case of abortion, it is up to them to find out, with parental consent, the reasons that led the girl to do this.

> *"... When they come here or when I visit them, I just ask what their problem is and accordingly I tell them whether I can help them and the price to be paid. But we have to talk to the patient and the patient sometimes explains a little of his life and how the problem he has emerged..."* (Traditional Healer Nhamatanda, Individual Interview).

Midwives and the godmothers of the female initiation rites are responsible for offering advice about the "proper" behavior of women at home and in society. They are also responsible for teaching the "art" of seduction and conquest, and about beauty and dressing appropriately.

Although mothers and fathers are among those involved in education, their participation is more general and to a certain point it is absent when it comes to discussing SSR. In general dialogue with the children is rare and when it exists it is very superficial. This reveals that the approach of sexuality between parents and children continues to belong to preventable aspects, marked by deep secrecy.

> *"... the indicated mothers or others who are experienced with respect to issues such as pregnancy, abortion, childbirth, menstruation and other health related things talk to the girls of the community ... the community leaders also talk but they always speak with authority, they tell young people how to behave ... they say that sex is forbidden and should not be practiced by girls and boys but at the same time they do "pitakufa" or those ceremonies sometimes seen with these children considered girls who are forbidden to have an active sex life...[original unintelligible]"* (Woman in charge of Education, Nhamatanda, Individual Interview).

5.2.1.5 RELATIONSHIP BETWEEN COMMUNITY, SCHOOL AND HEALTH UNIT

The relationship between these three educational levels is not felt at community level, which may reveal a latent conflict between tradition and modernity. Only in a few moments the PGB has held talks in schools, with the participation of community members.

> *"... From what we teach in the tradition, some aspects are passed on and discussed in school, but we never relate to it ..."* (Woman in charge of Education, Nhamatanda, Group Interview).

5.2.1.6 AVAILABLE HEALTH SERVICES

The community has the following health services dealing with SSR: traditional medicine treating cases of syphilis and gonorrhea by means of medicinal plants and treating tuberculosis resulting from exposure of the woman who aborted without performing the "pitakufa" ceremony. Traditional midwives also have an important role in controlling pregnancy and abortions. Other services offered by the State in the community are the counseling corners operated by the SSR activists and the ACSs.

From what was mentioned above it can be seen that there is a simultaneous demand for health care, however the primacy of one system as compared to the other is culturally conditioned, that is, the choices do not necessarily depend on the availability or unavailability of formal care, but there are other factors linked to social representations of health and disease that determine where and when to seek health care, among which are religion, beliefs and previous experiences of success or failure.

5.2.1.7 THE ROLE OF THE PARENTS IN EDUCATION ABOUT SSR

Parents rarely use the opportunities that exist to engage in dialogue with the school. It is noted that they (the parents) know little or nothing about what their children is told in school with respect to SSR education. Small opportunities arise at times when children need an explanation about SSR from their parents.

> *"... I am in charge of education but I have not been called yet to talk about sex education of our children ..."* (Guardian, Nhamatanda, Individual Interview).

Another reason that may contribute to the lack of interest by parents the education their children receive in school is related to the hierarchies that are established and the conflicts that exist between traditional and formal knowledge:

> *"... The school sometimes says that the guardians are reluctant and that they do not want the welfare of the children. This is not true because we all want a better future for our children, but they do not try to*

understand our view. So this conflict can be overcome when they start to respect our wishes...“ (Guardian, Nhamatanda, Group Interview).

5.2.1.8 KNOWLEDGE ON SSR TRANSMITTED AMONG YOUTH

It was observed in Nhamatanda that young people discuss a lot about SSR related questions. Conversations revolve around seduction and conquest of a woman and which women can be seduced. Young people are aware of the “prostitution” occurring in the district and also discuss this. There is mention of occasional contacts with “prostitutes” as a way of “relaxing”, although the use of condoms or some other form of preventing HIV and AIDS or other sexually transmitted diseases is not being mentioned. These conversations take the form of affirming identity and masculinity. The boys who do not engage in contacts with “prostitutes” are considered as impotent, not being real “men”. Conversations about “more serious” relationships revolve around the choice and preference for girls belonging to a “good family”, beauty and the way of dressing.

On the other hand youth discuss the ideal young man for dating and “cutting a good figure”. One of the conditions and aspects to be considered in the choice of a boyfriend is that he has to be a student and from a stable family, which can inspire a promising future for the girl while for “cutting a good figure” the boyfriend can be “anyone”, as long as he can pay for the expenses and wishes of the girl.

Another issue widely discussed among the youth is beauty and the most coveted woman, so therefore they teach one another tricks to attract and seduce a man such for example manipulating the labia using a plant so that the girl seems a virgin, stretching the labia and using beads in order to give the man more pleasure.

5.2.1.9 ROLE OF THE NGOS

The Health Alliance International (HAI) is an NGO working in the field of SSR in Nhamatanda, however this work is done at the health unit and is limited to financing the training of local SSAJ activists and the purchase of equipment at SDSMAS level.

5.2.1.10 POSSIBLE ENTRY POINTS FOR STRENGTHENING SSR

Uncles, grandmothers and godmothers are the possible entry points to strengthen SSR education because there is already a dialogue among these social actors and youth, and they play an important role in the educational process.

5.2.2 SCHOOL

5.2.2.1 WHAT IS TRANSMITTED

At school, the PGB activists transmit SSR knowledge related to menstruation, pregnancy, abortion, sex life (abstinence and not engaging in sex [any difference?] in exchange for money)., The girls receive education about precautions related to the menstrual period, including a ban on having sex aimed at avoiding sexually transmitted diseases, due in particular to not using condoms. With respect to menstruation [??] condom use and abstinence is also encouraged in order to prevent pregnancy and STIs.

The school teaches to have proper care during pregnancy, namely: rest and avoid heavy work. Education about pregnancy also reflects the imputation of the girl by forbidding her to attend day courses, she has to attend evening courses so that she “does not give a bad example to other girls.”

In the event of a miscarriage, the guardian and the educational institution advises the girl to go to the nearest health facility and to avoid the traditional treatment.

Education for boys also covers subjects concerning prevention by using condoms and, when they are younger, by abstinence. Both boys and girls receive advice on the need and importance of preparing for their future before assuming the role of fathers and mothers. As far as the relationship between parents and children is concerned the school encourages students to have an open dialogue with their parents about SSR.

Through lectures and discussions the school encourages boys and girls who already have an active sex life to prevent unwanted pregnancy and STIs.

> "... At school we learned about how to use condoms, how to practice abstinence, how to treat our bodies, how to avoid sexually transmitted diseases and STIs ..." *(Female pupil, Nhamatanda, Individual Interview).*

5.2.2.2 MECHANISMS OF EDUCATION ABOUT SSR

Knowledge is transmitted through lectures, theatre plays, advice and discussions, especially during the longer school breaks in the schoolyard. However, it should be noted that this activity appears to be ineffective because in this period the concentration of students is rather weak, often resulting in abandonment. The classes (Biology, Moral and Civic Education) are used by teachers across the board to transmit information about SSR to students through dialogue between teacher and students, as indicated by the interviewees:

> *"... The methods used are theatre plays, lectures, films, counselling corners and other means of dialogue ..."* (Student, Nhamatanda, Individual Interview).

> *"... The methods are lectures, classes, discussions. All these moments are accompanied by leaflets explaining all these things ..."* (Female Student, Nhamatanda, Individual Interview).

5.2.2.3 MAIN STAKEHOLDERS IN EDUCATION ABOUT SSR

The main stakeholders at school are the students, the student activists of PGB and the teachers. In addition to the PGB the EPC of Macorrococho has the nucleus for the fight against HIV and AIDS. This nucleus is led by activists who are also teachers, in addition to the peer educators consisting of teenagers and young pupils of the school.

> *"... They are the teachers, peer educators, activists, health professionals ..."* (District Official for SSR at Education level, Nhamatanda, Individual Interview).

5.2.2.4 ROLE OF THE STAKEHOLDERS

Activists of the PGB are responsible for showing pupils the mechanisms for preventing sexually transmitted diseases and they are responsible for the civic education of pupils concerning proper sexual conduct and practice.

The peer educators are responsible for transmitting their experience as pupils and youth who are sexually active but in a controlled and positive manner, encouraging abstinence or condom use during sexual intercourse, as well as being loyal. They are also responsible for encouraging socially accepted practices and attitudes in the school community.

> *"... The role of schools and teachers is to mitigate problems related to sexual and reproductive health, such as abortions and early pregnancies, to educate and explain to students how to lead a healthy sex life without necessarily having sex and getting pregnant before reaching the proper age..."* (District Official for SSR at Education level, Nhamatanda, Individual Interview).

5.2.2.5 RELATIONSHIP BETWEEN THE SCHOOL, COMMUNITY AND HEALTH UNIT

There is a relationship between the school and the community, although it is weak. Only at times when the guardians are invited to class meetings do they receive some information related to SSR from the pupils. The relationship between school and community is also contentious because the school recommends and makes pupils aware of condom use in sexual relations as the way to prevent STI, whereas the community discourages condom use and values abstinence and loyalty as mechanisms to prevent sexually transmitted diseases.

There is a relationship of partnership and complementarity with health facilities in SSR education. Health professionals give lectures in schools and inform about the services made available for questions about SSR.

5.2.2.6 AVAILABLE HEALTH SERVICES

The services offered by the school are the counseling corner in the Secondary and Pre-University School of Nhamatanda and the Nucleus for Fighting HIV and AIDS of the EPC in Macorrococho. Primary schools implement the basic package.

> *"... We collaborate with and get help from Geração Biz in this whole process, but it only serves secondary schools while basic packages that are discussed in primary schools ..."* (District official SSR Nhamatanda, Individual Interview).

5.2.2.7 THE ROLE OF THE PARENTS IN EDUCATION ABOUT SSR

In general parents have taken little advantage of the opportunities to have a dialogue with the school and to learn from their children what kind of education they receive at school.

> *"They are looking for it, yes. But mostly people look for these services when they have a problem and when everything is fine they don't. When it comes down to getting information no one goes, but when they have a problem or a concern they look for these services ..."* (Guardian, Nhamatanda, Individual Interview).

5.2.2.8 ROLE OF THE NGOS

The presence and performance of NGOs with regard to SSR education in schools in Nhamatanda are poor. The only thing mentioned was the training of school activists.

> *"... HAI has given us some help and training for our theater group but it is a long time ago ..."* (Activist, Nhamatanda, Individual Interview).

5.2.3 HEALTH UNIT

5.2.3.1 WHAT IS TRANSMITTED

In the health units women are taught that they should start having an active sex life only after reaching the age of 18, because then the body is physiologically prepared. Prohibitions also referred to include not having sex during menstruation, the use of condoms to prevent unwanted pregnancies and birth control by means of family planning. The health unit discourages the practice of abortion.

When they are pregnant, women are encouraged to do the HIV test and they are taught about precautions with food, as well as avoid heavy work. The health unit discourages pregnant women to seek traditional treatment during pregnancy because it is ineffective and unsafe. After childbirth women are informed on postnatal care and on the importance of breast milk during the first six months of the baby's life.

> *"…For women we do prenatal consultations, gynecology consultations, family planning and we give regular vaccinations, for contraception and also other ones to protect women and ensure their good health. For men we only do STI consultations..."* (District Official for SSR, Nhamatanda, Individual Interview).

Men are taught to do the test and visit the health services in case there is something wrong with their genitals. STI treatment is also encouraged, in order to prevent infertility.

5.2.3.2 MECHANISMS OF EDUCATION ABOUT SSR

Mechanisms used in the educational sphere are encounters between health workers and the community. IEC activities and presentations of films are other widespread mechanisms in the community.

> *"... Talks, discussions and meetings are held in communities and in the schools. We also have a dialogue with the SAAJ youth. We use pamphlets that explaining how to treat teenage girls and boys, we also use videos about HIV and AIDS, which are projected here in the hall of the SAAJ and youth come to watch them, there are other mechanisms too..."* (District Official for SSR, Nhamatanda, Individual Interview).

When a woman goes to the health unit, either for family planning, CPN, postnatal consultation, or for seeking advice, we use these occasions to make her aware about SSR.

5.2.3.3 MAIN STAKEHOLDERS

The main stakeholders are the health providers, the person responsible for sexual and reproductive health at district level, SAAJ activists, midwives and health workers from the maternity ward and SMI experts.

5.2.3.4 ROLE OF THE STAKEHOLDERS

The task of the health providers is to educate the community at large, but focusing on SSR in the case of youth. These professionals show the advantages of leading a regular and protected a life. These stakeholders also have to inform people on the health services that are available.

> *"... The providers are responsible for attending the youth and the problems they have, they also accompany young people in terms of education, counseling and treating diseases related to sex ..."* (District Official for SSR, Nhamatanda, Individual Interview).

The function of the person responsible for SSR at community level is to coordinate and direct the activities of the health workers with regard to SSR, to integrate the mobile brigade, to give talks on health and hold discussions on SSR.

Traditional midwives trained by the health unit are responsible for talking to mothers about the importance of family planning and the use of contraceptives use to avoid unwanted pregnancies and abortions.

5.2.3.5 RELATIONSHIP BETWEEN HEALTH UNIT, COMMUNITY AND SCHOOL

The relationship between the health unit and the community is still weak, although in some parts of the district there are for instance traditional midwives trained by the health unit who work together with this unit... There is a contradiction between the SSR education passed on in the community and that which is transmitted by the health unit. As has been mentioned before, there is a communication gap between these two educational levels.

> *"... There is no relationship and no collaboration whatsoever. Because if there were I think the kinds of things we talks about now would not have happened, the methods they use would be different and we would be giving the same education following the same principles or guidelines ..."* (Traditional Chiefs, Nhamatanda, Group Interview).

There is collaboration between the health unit and the school, given that the messages transmitted at school level and at the level of the health unit are the same and based on the same principles. If the health unit advises to have sex using a condom the school reiterates the same point. Many SSR activities by the health unit have the schools as their target group.

5.2.3.6 AVAILABLE HEALTH SERVICES

In Nhamatanda voluntary counseling and testing services, family planning and STI treatment are available at district level. SAAJ is available for youth.

> *"... For women we have contraceptives, cerclage, an intra-uterine device that protects women against pregnancy, contraceptive injections and the pill, while we have condoms for men. For women we have the mobile brigade that, in addition to moving from place to place in order to vaccinate children and raise awareness about sexually transmitted diseases, includes health workers who talk about sexual and reproductive health while at the same time advise women to go to health centers to do the test ... "* (Director of the Rural Hospital of Nhamatanda, Individual Interview).

5.3 CHARACTERISTICS OF EDUCATION ABOUT SSR IN ZAVALA

5.3.1 COMMUNITY

In Zavala, the investigation found that the SSR education is based on gender differentiation, it concerns little discussed aspects and it takes place in a "closed" manner, and using taboos in order to strengthen the mechanisms for controlling sexuality. It was found that the teachings in the community focus more on girls than on boys. This shows how social expectations of being male or female are perceived and interpreted, where the first category (being a man) is in itself sufficient while being a woman necessarily calls for social learning and requires more rigid control mechanisms.

5.3.1.1 WHAT IS TRANSMITTED

The investigation found that both interviewed girls and boys reportedly start being sexually active after reaching 18 years of age because being sexually active means growth and responsibility. However, it should be noted that the observations made contradict these statements because it was found that girls and boys in Zavala start

being sexually active before they are 18, with many cases of premature pregnancies and girls studying at night classes because they have become mothers.

The girls are still taught that during the menstrual period they cannot have sex with their partner and they have to rigorously observe hygienic precautions so that others are not aware that they are menstruating because the menstrual cycle is perceived as a dangerous phase, the source of contamination with impurities.

> *"During the menstrual cycle the woman here is forbidden to have sex with any man because the man can get sick, get a hernia or vomit blood. During this period a woman can carry out their activities such as cooking, but in the past she could not approach the kitchen. This prohibition also holds when the woman has a miscarriage (...)"* (Guardian, Zavala, Group Interview).

As far as pregnancy is concerned the community has teachings associated with prohibitions and permissions. Regarding these permissions, the woman is taught that pregnancy is the appearance of a new family member, something which requires a certain responsibility and care for the proper development of the pregnancy until the baby is born.

During this phase she should have a healthy diet and from the 7th month onwards she is forbidden to have sex with her husband because, otherwise, the child may be born with "filth", which is shameful when seen by health workers. At this stage the woman should lie on her side and not on the stomach to avoid harming the health of the child. The pregnant woman is also advised not to have sex with multiple men because the mixing of "blood" may result in a miscarriage. The prohibitions also include not executing heavy work.

> *"(...) When she is pregnant a woman cannot have sex with men other than her husband because the mixing of different blood may disfigure the baby and she can have a miscarriage or a stillborn baby"* (Guardians, Zavala, Group Interview).

The community advises a pregnant women to go to hospital for antenatal consultations but she is also advised to visit the traditional healer to receive traditional treatments aimed at avoiding risks associated with pregnancy. These treatments also serve to facilitate and accelerate childbirth and to eliminate certain diseases, such as "Txiwumba" [12], which may occur in pregnant women.

The pregnant woman is also advised to consult a religious prophet in order to see if she has a spirit that may complicate her delivery, and if that is the case the prophet expels this spirit and she has a normal delivery.

> *"The locally transmitted knowledge about pregnancy is that the pregnant woman should go to hospital or the religious prophet so that they accompany the pregnancy because pregnancy is a sign of the coming of a new person in the family. The prophet or the hospital will check whether the pregnancy is developing well, the prophet in particular has to see to it that the mother does not have a spirit that might complicate the delivery, if she has that spirit the prophet expels it and childbirth will be normal"* (Godmother, Zavala, Individual Interview).

The persons in charge of education mention that it is forbidden to permanently use contraceptives because they may make it difficult for women to get pregnant by causing sterility This prohibition is based on the idea that

[12] This disease develops in the woman's genitals and if it has not been treated traditionally at the time of delivery the child may die during childbirth upon touching the infected part of the woman's vagina.

rearing children means wealth for the family and a woman who does not have children has no value and is rejected by the community.

> *"(...) the pregnancy is a sign that we are extending the family, we are multiplying. People get married to have children Having a woman who cannot have children is a problem, a pregnancy is a blessing"* (Guardian, Zavala, Group Interview).

> *"We leaders and priests of Islam do not really recommend the use of contraceptives because they cause other health problems, such as infections in women, but we do advise to use condoms"* (Muslim Religious Leader, Zavala, Individual Interview).

The community also discourages avoiding pregnancy by conventional means. One of the requirements of the traditional treatment for avoiding pregnancy is for the PMT [meaning?] to inter some products [products?] If people change residence or the PMT dies without the knowledge of the women receiving the treatment, then the woman may become permanently sterile because only the PMT who knows how to undo the treatment [original unintelligible].

For delivery outside health units the teachings concern the woman's behavior, she should not scream because it may frighten women who have not had children yet, and also because the neighbors should not be aware that a child was born or is being born.

After delivery the ban on having sex still holds because the child is still small and its health may be affected because it cannot drink the pregnant mother's milk [??]. At community level there is no clear understanding about when to end the ban on having sex.

Abortion is viewed negatively by the community so it should not be practiced. If a woman has a miscarriage she is not condemned by the community because it is believed that it may not have happened through negligence of the woman, but because of "sorcery".

In case of an abortion the woman is advised to look for a traditional healer who can remove any "filth" or to go to the health unit in order to receive medical care. The traditional medicine treatment requires that the woman abstains from having sex with a man for at least three months, compared to what is done in the health unit [??].

A woman should also abstain from having sex after an abortion because when the man comes into contact with the woman's blood he may get a cough and vomit blood, which causes a hernia and he may even die. Therefore women are taught that they should not hide having had an abortion so that men can take precautions.

Education for boys boils down to performing circumcision. Circumcision is seen as a rite of passage to adulthood, thus the man who has not been circumcised yet is considered a child and discriminated against in the community. Interviewees mentioned that changes are taking place with respect to circumcision. It used to take place during a period that could last up to two months. At present circumcision is done in health units and it has been explained as the cleaning of the male genitals. Although circumcision is now done in health units it has not lost its symbolic value, because in Zavala he who underwent circumcision is considered a man.

5.3.1.2 MECHANISMS OF EDUCATION ABOUT SSR

SSR education is transmitted through recommendations, advice or conversations by paternal uncles and aunts. In Zavala the parents have a larger role as compared to the other districts because here they can also talk to

and advise their children. The role of parents may be understood within a context in which specific rituals for the transmission of knowledge on SSR to youth are absent.

> *"A family may decide to talk about pregnancy with their children or even what it was being a father at the time, but if you do not want to talk don't talk, it depends very much on each family"* (Godfather of Baptism, Zavala, Individual Interview).

In some cases recommendations and advice are also transmitted by the elderly in the community because it is believed that they have more experience and some parents believe their children will heed the advice they are given by an "outsider". This process takes recourse to people who are looked upon as successful in the community.

Religion also plays a role in educating youth about SSR. The religions from the district are the Roman Catholic and Zionist churches and Islam in particular. Islam has transmitted teachings to its believers worshipping on Fridays. Muslim leaders have promoted condom use for the prevention of STIs and HIV and AIDS, but they discourage excessive use of contraceptives like the pill, because in their perception these create health problems for women.

In meetings with mothers who are believers the Catholic and Zionist churches have been referring to SSR. One of the things mentioned is the prohibition of abortion because it is against the commandments of God's law. Also mentioned are abstinence and fidelity.

Another other form of passing on education has been through lectures and theater plays organized by community activists. These concern all ages, beginning at puberty and for women in particular after the first period, while the timing for boys varies.

5.3.1.3 MAIN STAKEHOLDERS

The main stakeholders in Zavala are mothers, fathers, paternal aunts and uncles, community activists, religious leaders and the elderly who command a certain respect and recognition within the community.

5.3.1.4 ROLE OF STAKEHOLDERS

The role of these social actors varies from location to location and from family to family. In some families the role of the mother or father in educating the children is more important, while in other families it may be the elderly from the area who play a role on behalf of the parents.

> "The girls are taught by the mother or the father's sister what dating is, that they should not have sex early because they may become pregnant or get diseases, they are still children" (Community and Religious Leaders, Zavala, Group Interview).

Mothers and paternal aunts are responsible for advising and guiding the daughters or nieces about their conduct when they face men after the first menstruation, as well as about the precautions to be taken during the menstrual cycle. They teach them about when to start dating and if the girl is older than 18, the aunts teach her when she can have sex while preventing pregnancy and STIs.

Parents and parental uncles are responsible for transmitting knowledge to boys. They teach them how they should choose a woman and how they should behave in order to avoid contracting diseases. They also teach the boy how to be responsible and explain the value of circumcision. Some interviews revealed that parents

push boys to test their virility and girls their fertility because a man cannot have a woman who cannot have children.

The activists have a role in transmitting messages to the community about prevention of STIs and HIV and AIDS, about condom use and condom distribution. Civic education about individual and collective hygiene, prevention of unwanted and premature pregnancies [something missing?].

Religious leaders have the responsibility to teach their believers during services or masses about the protection they should seek against STIs through abstinence and fidelity and about how to prevent unwanted pregnancies. Islam encourages condom use in its teachings, as indicated in the extract below:

> *"Church leaders teach the faithful to use condoms in order to prevent sexually transmitted diseases. They teach pregnant women to go to hospital so that doctors can monitor the pregnancy and avoid the death of mother and baby. We have advised mothers who had an abortion to go to the hospital to receive medical care. We also teach the believers that during and after childbirth they should arrange a clean place suitable for the baby so that they protect the child against diseases and that mother and baby should to the hospital to be monitored"* (Muslim Religious Leader, Zavala, Individual Interview).

The elderly in the community are responsible for transmitting to young people the habits, practices, rituals and behavior that the community in general should adopt. In these teaching the elderly refer to best practices and attitudes concerning SSR in the past, as a way of advising young people about proper behaviour.

5.3.1.5 RELATIONSHIP BETWEEN COMMUNITY, SCHOOL AND HEALTH UNIT

The relationship between the community and the school is not visible. There is a conflict between community and school, part of the interviewees are of the opinion that the education their children receive in school belittles the knowledge transmitted by the community. Parents also disagreed with the distribution of condoms at school because in their view it encourages prostitution, promiscuity and unwanted pregnancies and besides, condoms are not used with due regularity:

> *"The government is to blame for this lack of respect that children show for their parents and for the pregnancies occurring. We as parents cannot call our children to order because the government protects them and tells us we engage in domestic violence. Parents no longer have a say in the education of their own children"* (Traditional and Religious Chiefs, Zavala, Group Interview).

The relationship with the area of health is visible. There is an ACS chosen by the community who serves as a link between the two spheres. He provides information about what happens in the community and helps to identify the health problems the community is facing. The role of the ACS is also to inform the traditional leaders on the talks given by the health unit and these leaders in turn invite the communities.

> *"When the health unit is aware that the community will come together in some place, they join in and use the occasion to vaccinate children and give talks about diseases such as HIV and AIDS. Here in the community there is a health worker who serves as liaison between the community and Health"* (Traditional Chief, Zavala, Individual Interview).

Some matrons who assist childbirths in the community received training at the Quissico Health Center about the precautions necessary to avoid contracting diseases or transmitting them to the pregnant mother.

> *"Yes there is the relationship with the authorities of the national health system because I received training from them and they gave me some material to work with in the community"* (Matron, Zavala, Individual Interview).

5.3.1.6 AVAILABLE HEALTH SERVICES

The health services available in the community are traditional medicine, which deals with problems of infertility in women such as "*xithetho*", impotence in men, gonorrhea and syphilis by means of medicinal plants and roots. There are also prophets who exorcize evil spirits that disturb the proper course of the pregnancy.

> *"I take care of women who run the risk of having a miscarriage during pregnancy, I treat women who aborted and clean what is still left in their belly using roots and herbs, I treat the disease a man contracts when he has sex with a woman who had an abortion. The man appears with a cough and when he begins to cough he spits out blood. I also treat a type of sterility in women called 'Xithetho'"* (Practitioner of Traditional Medicine, Zavala, Individual Interview).

5.3.1.7 THE ROLE OF THE PARENTS IN EDUCATION ABOUT SSR

Although in some families the parents are among the main stakeholders in SSR education for youth in the community, in general they do not use the opportunities they have to either have a dialogue with the school or with their own children about SSR. It was also found that the SSR subject is not openly discussed between parents and children.

5.3.1.8 KNOWLEDGE ABOUT SSR TRANSMITTED AMONG YOUTH

The observation made in Zavala reveals that youth have had some conversations about delaying their first sexual activity, fidelity and condom use to prevent pregnancy and STIs. However, experience shows that these teachings are not applied because girls between 13 and 15 years of age get pregnant while boys refuse to take responsibility for these pregnancies and ultimately they become the responsibility of the girls' parents.

5.3.1.9 ROLE OF THE NGOS

There are three NGOs in the district that develop programmes and activities around SSR, but the one that has done something visible is Samaritan's Purse. This NGO is often mentioned by the residents for its accomplishments in the community. Its interventions are geared towards HIV and AIDS.

Samaritan's Purse implement six programmes: Mobilize, Educate and Train communities - MET; Home Care for people living with HIV/AIDS; Patient care; assistance to orphaned and vulnerable children; Food Aid to Patients - WFP and the last program is the active search of patients who abandoned ARV treatment.

The NGO trained some activists from local community associations such as the Association *Kulane Kuata Vanana*[13] (AKKV) about SSR issues so that they can serve the community. It is through the activists that the institution offers advice to communities, churches and schools.

[13] Meaning in Portuguese that children grow peacefully.

The institution does not promote condom use because it contradicts its religion. The other NGOs who are involved in the area of sexual and reproductive health in the district, such as Childfound [correct name?] promote condom use. Nevertheless they exchange experience among one another.

Samaritan's Purse implements its programmes with the objective of helping youth to make the best choice in the prevention of HIV and AIDS. Its target group is the population between 14 to 49 years of age.

> *"The purpose of the implementation of the programmes is to help young people to make the best choice in preventing HIV/AIDS. By implementing these programmes we hope to change the sexual conduct of young people between 14 and 49, because these are our main target group in the fight against HIV/AIDS"* (NGO Representative, Zavala, Individual Interview).

5.3.1.10 POSSIBLE CHANNELS TO IMPROVE SSR

Possible entry points for improving SSR in the district of Zavala are the paternal uncles and aunts who are the main stakeholders in SSR education. The fathers and mothers may also constitute an entry point because at times they also play a role in educating their children.

5.3.2. SCHOOL

5.3.2.1 WHAT IS TRANSMITTED

The contents passed on in the schools focus on caring for one's body, the male and female reproductive system, issues related to HIV and AIDS including modes of infection and prevention, and treatment. The contents also include the respect for parents, delaying the start of engaging in sexual activity and the importance of contraceptives in avoiding unwanted pregnancies. The education for boys is geared towards fidelity after having initiated sexual activity.

> *"This education consists in teaching students about HIV and AIDS, the way it is transmitted, about prevention and how to fight it and how to deal with a person who has contracted the disease. We teach the pupils about other sexually transmitted infections, such as gonorrhea, syphilis, vaginal discharge. Pupils are informed about premature pregnancy, its prevention in order to forestall girls leaving school and premature marriage, and about condom use"* (District Representative Education, Zavala, Individual Interview).

5.3.2.2 MECHANISMS OF EDUCATION ABOUT SSR

Education is transmitted through dialogue between teachers and students in the classroom, in the school's counseling corner or even in the hallway. The methods used for passing on knowledge in school are lectures, theatre plays, song and dance, and discussions. Moments used to pass on information in school occur mainly during biology classes and during the class meetings held on Wednesdays. The school has a counseling corner of the PGB where students seek counseling after school or during breaks.

> *"(...) Information is transmitted during class lessons Portuguese, Biology, English and History because it is already included in the teaching programme (...)"* (Teacher, Zavala, Individual Interview).

> *"In order to convey these messages the school uses textbooks with information on SSR, CDs, posters, pamphlets, lectures, theater, singing, dancing. In biology lessons we learned about SSR. The school has a counseling corner and in between classes students go to the corner and get information on*

> *various subjects. On Wednesdays the classes have a meeting with the class director and the teachers use this occasion to talk about issues related to SSR"* (Pupil, Zavala, Individual Interview).

Education is passed from grade 7 onwards up to grade 11 only because the district does not have a grade 12. In Zavala not all schools have an SSR program, the Secondary School of Chitodo south of the town of Zandamela [? what about it, it has one or not?]. The situation differs from one level to another, for students who are in 8th grade and for those in 11th grade...

5.3.2.3 MAIN STAKEHOLDERS

The main stakeholders are the teachers, including the Director of the School, PGB activists, students, peer educators and activists of local associations.

> *"Who teaches are the teachers and activists who are trained by the Geração Biz programme. Teachers transmit knowledge during their classes whenever possible"* (Teacher, Zavala, Individual Interview).

5.3.2.4 ROLE OF THE STAKEHOLDERS

Teachers and the school principal have the responsibility to teach and make pupils aware about behavioural change and prevention of STIs, HIV and AIDS, and unwanted and premature pregnancies. The teachers are responsible for producing information, articles and for organizing lectures, theater plays, songs and dances about sexual and reproductive health and for monitoring the group of activists who have assisted in advising their classmates through songs. They are also responsible for encouraging the guardians to authorize the participation of the children in performing theater plays. They also counsel and refer students to the SAAJ Health Center in Quissico when students come up with complicated situations.

> *"The role of teachers is to support pupils in changing their behaviour, to raise awareness so that they know how to protect themselves against STIs and how to prevent pregnancy. Teachers organize lectures, make newspapers with messages about SSR and place them on the walls, they counsel and refer pupils to the Adolescent and Youth Friendly Services (SAAJ) in the Health Center of Quissico"* (Teacher, Zavala, Individual Interview).

The PGB activists and peer educators are responsible for advising their fellow pupils about the importance of HIV and AIDS testing and condom use for boys and girls who have already initiated sexual activities. They are also responsible for advising students to avoid multiple relationships in order to avoid infection with STI and HIV and AIDS. These activists are also responsible for counseling in the school's counseling corner.

5.3.2.5 RELATIONSHIP BETWEEN SCHOOL, COMMUNITY AND HEALTH UNIT

The relationship between school and community is almost nonexistent. School and health units have a partnership recognized by the district and provincial services of Education and Health, to the extent that some teachers received training and capacity building from Health on the different topics related to sexual and reproductive health. They were also trained on HIV and AIDS, sexual rights and other problems affecting young people.

> *"We do have teachers who were trained in SSR. The training was given in 2007 and 73 teachers received training at district level. They learned about sexual rights, HIV and AIDS and about pregnancy. They were trained to function as school activists and were prepared to handle any type of sexual and reproductive health status, behaviour and attitudes of different pupils at school. The training of teachers*

was given by doctors from Inhambane province" (District Representative Education, Zavala, Individual Interview).

After the training on SSR the teachers generally have a different attitude in approaching these questions. Issues such as shame and fear to talk about these things become less important. The need for greater support to adolescents and youth grows significantly after training. Information is offered through lectures and awareness raising in meetings and in the classroom. Teachers now have the proactive role of educators and adolescents and youth have a more active role in raising awareness, education and promotion of SSR.

5.3.2.6 AVAILABLE HEALTH SERVICES

Services available in the school are the counseling corner that also provides Information, Education and Communication (IEC) materials including pamphlets, CDs with messages about HIV, AIDS and other STIs, which are distributed among pupils. The Secondary School of Quissico is the only one that has a counseling corner.

5.3.2.7 THE ROLE OF THE PARENTS IN EDUCATION ABOUT SSR

The survey found that parents do not use the existing opportunities in schools (counseling corners) to find out more about the education received in school. This lack of dialogue with regard to SSR is even more evident among parents and children.

5.3.2.8 KNOWLEDGE ABOUT SSR TRANSMITTED AMONG YOUTH

Young people have discussed the various contents transmitted by teachers and activists. These conversations emphasize the prevention of pregnancy and of STIs, including HIV and AIDS. There is also a dialogue about delaying the initiation of sexual activity

5.3.2.9 ROLE OF NGOS

Generally speaking the role of NGOs in school is not very visible because there are no SSR programmes at school level being implemented by NGOs

5.3.3 HEALTH UNIT

5.3.3.1 WHAT IS TRANSMITTED

SSR education is more geared towards women because men do not often visit the health unit to get information on SSR. The women are taught about the importance of family planning and about the prevention of premature and unwanted pregnancies. Women are also made aware of the importance to deliver the baby in the health unit so that it can receive all care, of waiting at least two years before getting pregnant again and of the appropriate number of children. Both men and women receive information about the importance of HIV testing, of collective care and of not using the same cutting instruments so as to avoid HIV.

"The education given to pregnant women concerns the importance of family planning, the importance of hospital delivery (...)" (District Representative SSR, Zavala, Individual Interview).

Women who live far from the health unit are advised to go to the homes of the mothers-in-waiting[14] and they are taught to avoid clandestine abortions using roots and other traditional medicines. Women and men are advised to test on HIV, AIDS and other STIs.

> *"Families who live far from the health center are advised to wait for the childbirth in the hospital, to avoid* clandestine abortions *using roots and other medicines because they cause fatalities, and they are informed about the importance of testing on HIV, AIDS and other STIs, and about condom use"* (District Representative SSR, Zavala, Individual Interview).

5.3.3.2 MECHANISMS OF EDUCATION ABOUT SSR

Education is transmitted through lectures organized by professionals from the health centers in the early hours before starting their activities, through conversations and counseling in the SAAJ, through visits to communities by mobile health brigades and through the distribution of IEC material.

> *"We give this education through lectures, we distribute leaflets with information on SSR, magazines, condoms, we talk about HIV testing"* (Chief Nurse Quissico health centre, Zavala, Individual Interview).

5.3.3.3 MAIN STAKEHOLDERS

The main stakeholders are the SMI nurses, doctors, activists and matrons recognized by the health services.

5.3.3.4 ROLE OF THE STAKEHOLDERS

The medical doctors are responsible for the lectures and counseling to all patients looking for the services that are available in the health units. Later on tests may be carried out in accordance with the patient's reasons for visiting the health unit.

The SMI nurses have the role to advise mothers on CPN, on the importance of HIV testing and on delivering their babies in the health unit. The role of the activists is to do the counseling and assist the nurses in their activities at community level and within the SAAJ in the health center.

The role of the matrons is to assist the childbirth in the community if the woman is unable to reach the health unit on time, and subsequently to refer the woman to the health unit. They also assist childbirth in the health unit. The activists are also responsible for giving lectures.

5.3.3.5 RELATIONSHIP BETWEEN HEALTH UNIT, COMMUNITY AND SCHOOL

The health unit has a relationship with the community through the ACSs chosen by the community. The ACS is responsible for coordinating the health unit's awareness raising in the community.

Practitioners of traditional medicine and health workers from the health units exchange experiences. Meetings are held where traditional health practitioners share their knowledge about curing HIV-associated opportunistic infections using plants and roots. The health workers in turn share with practitioners of traditional medicine the health unit's existing procedures concerning HIV and AIDS, in particular testing and treatment.

[14] These are the places close to the health unit where pregnant women await childbirth. In general these houses are occupied by women living far away from the health unit.

Sometimes Health trains traditional chiefs in SSR matters and these pass on the local cultural habits related to SSR in the community to nurses and doctors.

> *"(...) the traditional healers say that they treat HIV using plants and roots and in turn the doctors and nurses from the health unit talk about their experience, by informing that in the case of HIV/AIDS they do a test first and only then start the treatment, but the treatment does not cure, it only decreases the viral load. Formal education on SSR in hospitals is complemented by traditional education on sexual and reproductive health"* (Nurse, Zavala, Individual Interview).

The health sector informs young people from the community about SSR issues, which are then replicated at community level. These youth hold talks in the community about HIV and AIDS, condom use, the prevention of unwanted and premature pregnancies and in case of complicated illnesses the activists refer the ill to the health unit.

There is a relationship between the health unit and the school to the extent that the health sector facilitates the training of teachers in some SSR subjects. Health workers also give talks in schools.

> *"The professionals of the health center have gone to schools to give talks to women of childbearing age-MIF"* (Chief Nurse, Zavala, Individual Interview).

5.3.3.6 AVAILABLE HEALTH SERVICES

The health unit has family planning services, PTV, STI testing and treatment, including of HIV. Specifically for young people to health unit has a SAAJ.

> *"The types of services we have are: health education, prevention of STIs and pregnancy, including family planning and childbirth services, antenatal consultations, prevention of vertical transmission from an HIV-positive mother to child, treatment of infections in people living with HIV and AIDS, and tests. Health education in general covers both men and women"* (District Representative SSR, Zavala, Individual Interview).

VI. JOINT ANALYSIS OF THE RESULTS

In this section of the report we intend to show the common aspects and the differences between the four districts that were investigated, weighing the specificity or generality that can be analytically attributed to them.

VI.1 SIMILARITIES

As far as the teachings are concerned the present study allows us to understand that in the four investigated localities the cultural practices with respect to SSR, the channels and mechanisms of education, the learning context and the main stakeholders in the educational process do not differ significantly, given that people are taught about SSR in the community, the health units and in the schools.

Education at community level remains rooted in the traditional practices that have been described, such as, among others, initiation rites, religion, taboos (*swayila*), traditional medicine (Graça, 2002), as well as by practices involving the vagina (Bagnol & Mariano, 2006), while "emerging practices" are characterized by the "new" approaches to sexuality and SSR, such as condom use, gender equality, sexual and reproductive rights, safe motherhood including family planning, greater involvement of men in sexual and reproductive health activities, which are incorporated in school curricula at different educational levels and are as well introduced by ACSs, technical personnel from the health sector, the media and NGOs

Although this second group of practices (the emerging ones) is growing in the four investigated localities, it is still less significant in shaping the attitudes and conduct both of the people responsible for education as well as of the educated youth at the moment in which they need to put this knowledge about sexuality, sexual and reproductive health into practice.

The above state of affairs occurs because, according to (Paul, 2009), sex education in Mozambique does not link the socio-cultural aspects, the pressure from family, religious beliefs and macroeconomic forces with the messages that are transmitted.

Traditional practices at community level pass on SSR teachings exclusively for boys and for girls through the initiation rites, with the exception of Zavala where these teachings are not considered to be [part of?] initiation rites, although their content and form are akin to what in Nampula and Sofala is called just that.

Initiation rites are a practice that allows participants to pass on to a new stage in their life, something that in the community is seen as signifying their growth, and which also defines the identity of the individual. Therefore all boys and girls are advised to undergo this phase of instruction.

According to (Graça, 2002) and (Medeiros, 1997) initiation rites mark the end of adolescence the start of adulthood. Generally speaking they serve to educate boys and girls in certain codes of conduct with respect to the phase of life that is about to begin. Among a range of aspects the provided teachings dynamically include sexual and reproductive education (Mariano, 2007).

Education transmitted to girls at community level focuses more on the form of their new social role as wife that they are about to assume. In addition to these aspects is also transmitted a set of knowledge about precautions related to the menstrual cycle, pregnancy, the period immediately after childbirth, abortion, and mechanisms for

the management of matrimony and sex life using various practices such as stretching of the minor labia and lessons on how to sexually please the husband.

In general the main stakeholders in the educational process are the godfathers, godmothers, matrons, PMT, religious leaders, SMI nurses, doctors, teachers and student activists, with the exception of Nhamatanda and Zavala where parental grandparents and uncles and the parents, with a secondary role, are involved as well

The periods in which these teachings begin differ significantly. For girls the onset is marked by the first menstruation, which represents and symbolizes the achievement of three phases of preparedness: sexual (the woman is ready to initiate sexual activity because she is "grown up" now), reproductive (the woman is ready conceive babies) and marital (the woman can marry now and carry out all other domestic activities). Thus for girls initiation confirms their femininity and prepares them socially and physically for their future social role as wife and mother (Salmon, 1991).

For boys this moment in time is variable and this variability partly shows the lack of rigidity of male education due to, among other things, the perception that matters regarding male sexuality are previously and naturally determined while for women it is essential to undergo a social and ritualistic preparation to that end.

This disparity in the attention given to boys and girls supports the idea advocated by (Loforte, 2003) according to which sexuality is configured by reproductive, social, economic and religious roles played by men and women in society and that in Mozambique there are inequities and values [? not clear to me what is meant here] in sexual and reproductive health (Loforte, 2007a).

The educational moments found in "emerging practices" are antenatal consultations, counseling, lectures and educational theater plays. As for as the school and the health unit are concerned the issues most addressed are condom use, HIV and AIDS prevention, family planning, antenatal and postnatal consultations and voluntary testing. The key stakeholders in the school and health units are the teachers, activists, SSR providers [?] and

SMI professionals.

Generally speaking the role of the school in terms of SSR education is still very inchoate with only a few sporadic activities being carried out, such as lectures and counseling during meetings of students, in Biology and Moral and Civic Education lessons, and during sports activities. In addition to these aspects the existence of counseling corners should be noted. The main topics dealt with are premature pregnancy, condom use, abstinence and HIV and AIDS. At school level the teaching cycle begins at secondary level, although there is the Basic Programme Package.

The health units transmit knowledge about SSRH within the context of the services they provide. The main SSR-related services are SMI, ART and SAAJs.

VI.2 DIFFERENCES

The differences were found at the level of the persons responsible for education and they are revealing in their differentiation of the type of society that each locality belongs to. Thus, in the communities of Nhamatanda and Zavala (patrilineal societies) the paternal grandfathers and uncles are the pillars of transmission of knowledge to

the boys, whereas for girls the educational responsibilities lie with the paternal aunts and grandmothers. The main difference we found in this regard is the fact that while in Nampula this education is delegated to godmothers and matrons in patrilineal societies the presence of these social actors in SSR education for girls is not felt to a great extent.

The marginal role of parents in the educational process in the studied localities of the province of Nampula in particular reveals that although the socialization of sexuality is being planned in the domestic sphere, its implementation should be entrusted to third parties as a way to ensure and maintain what is culturally and symbolically acceptable and the distance between parents and children in addressing these issues. Yet even the social actors to whom this education is entrusted are to be treated with deep respect and rules are imposed according to which the "student" not only should obey but also avoid his "teacher" to the maximum extent possible, as a sign of respect and acceptance of the sacredness of the teachings.

For girls this scenario characterized by the poor participation of parents in the educational process is not a special feature of Nampula, given that it can be traced all over Africa where initiation is concerned.

> *"(...) it is not the mother who is involved in the initiation process, but generally the aunt, the grandmother or a woman friend. These people are responsible for instructing the girl about matrimony (Salmon, 1991)."*

In the specific case of Mossuril the initiation rites of the girl are conducted mainly in three phases, namely: the first phase after the start of the menstrual cycle. At this stage the matrons teach the girls about the precautions to take with menstruation, as well as about all aspects related to prohibitions and permissions that accompany this state. This ceremony is usually held during the course of two days and is accompanied by singing and drumming and the teachings are transmitted in the form of counseling and intimidating phrases aimed at frightening the girl about the new experience that lies ahead. Usually a meal is prepared on the second day for the matrons in charge of transmitting the teachings, as well as for the family members present.

The second phase of the rites is carried out in order to pass on teachings the girl about how she is to behave in the presence of a man, stressing that she is already an adult person.

At this stage the girl learns things about her conduct during the sexual act, including information about pleasing the man, the care for her [his?] body and the way to behave after the wedding. This phase does not last for a specific period and it may even coincide with the period prior to the marriage, taking advantage of transmitting the teachings on the woman's conduct at home and all the skills that a woman should have to ensure marital stability. On other moments is also transmitted knowledge about care to be taken during pregnancy, after childbirth an in case of an abortion.

The third phase of the initiation rites consists in preparing the girl for marriage. Two to three days before the wedding the matrons gather at the home of the girl with the primary purpose of advising her on her conduct as a wife. This ceremony is accompanied by songs and dances where the "little lady" and her companions, who may be friends or cousins, are identified by painted faces and leaves of some tree placed on the head. The songs and dances contain derogatory and mocking messages about the male genitals and also use gestures to imitate the sexual act. This preparation ceremony also includes body care designed to make the woman beautiful for her husband.

Islam is practiced by more than 80% and also has an important role in educating young people on SSR. The girl is taught about the precautions related to menstruation, including the prohibition to attend the mosque when she has her period, and about her conduct at home. The boys are taught about their conduct after the wedding.

In Ribáuè and Mossuril the education of the boys takes place by means of initiation rites lasting a relatively long period that may last for up to a month. During this period the boys stay in a place relatively distant from home, where they are circumcised and taught about the way they are supposed to behave, including respect for the elderly and the prohibitions associated to this.

In Nhamatanda and Zavala the educational moment that marks the passage from adolescence to adulthood of boys features practices, among which the construction of the proper home by the youth, signaling that he is ready to start adult life, that is, to join a woman. Although this practice can be found in various families it does not constitute a cultural pattern followed by the community at large.

These differentiations illustrate that "sexuality" as referred to by Bagnol & Mariano (2006) is not a "natural" object but a historical product, that is, a cultural construct that varies according to the socio-cultural contexts, in other words people construct sexuality around context-specific notions and practices. That is why the approach of sexuality requires a systematic analysis of the cultural symbols of a society or social group, cultural relativism and inter-cultural comparison (Almeida, 2003).

VI.3 RELATIONSHIPS BETWEEN THE EDUCATIONAL SPHERES: COMMUNITY, SCHOOL AND HEALTH UNIT

The relationship between community and school in terms of spheres of learning is still weak if we take into account that the parents do not make an effort to find out what their children learn about SSR in school. The godfathers and godmothers of the initiation rites, the matrons and the elderly argue that there is no way to share the contents of "traditional" and "formal" education because the traditional approach is steeped in secrecy that must be maintained to the extent that it structures the construction of the social roles of men and women.

This weakness, reflected in the communication between the traditional and formal systems, partly derives from an unbalanced power relation where for example teachers and health providers are perceived and perceive themselves as possessing knowledge that guides and drives transformations that are to be systematically introduced in a community understood by formal education as a bulwark of "backward" and outdated knowledge closely related to tradition, which needs to be replaced by other knowledge considered "modern".

This poor relationship is also shown by the absence of dialogue that recognizes the role of different systems of education with respect to SSR. On the other hand [??] there seems to be a contradiction between the teachings transmitted in the community and those in school and in the health unit because at community level the girl is ready to marry and have children after the first menstruation whereas in some cases the school and the health unit encourage her to delay the initiation of sexual activity.

This means that there is a communication void between the "traditional" and "emerging" practices to the extent that in the "emerging" practices the cultural heterogeneity that characterizes the country is not reflected in the transmitted messages, but on the other hand the "traditional" practices contain SSR values and principles that are hard to square with "new" values that give another dynamic to local traditions and cultures.

Up to a certain point there exists a kind of "conflict" between the community and the school because the school transmits teachings in the same space for boys and girls, and in addition that this education is given in an "open and transparent" manner, which is not usually the case in the community.

Partly as a result of this secrecy it turns out that parents have little interest in establishing a dialogue with either the school or with the health unit or even with their children about the teachings about SSR passed on to them outside the family sphere. There is a serious generation conflict between parents and children, the first claiming

that today's youth show no respect and do not heed the advice of their elders, because their conduct is heavily influenced by modernity. Youngsters in turn disagree with the elderly saying that these do not follow the cultural dynamics that exposes them to the cultural diversity resulting from globalization.

The existing channels to promote dialogue between school and community, such as school boards and pedagogical influence Zones (ZIP) are not fully exploited and the complementarity between the two educational moments is not as yet being felt, given that traditional and formal education remain relatively distant spheres of socialization.

VII. CONCLUSIONS

The present investigation shows that in the four studied districts teachings on SSR are passed on in the community, the school and the health unities. The interview data reveal that at community level these teachings are transmitted based on differentiation in an unequal gender perspective because it is assumed that in general women have to learn all about sexual conduct and SSRH, while the education of men puts more emphasizes on the attitude that they should have towards the elderly, the role of being a man and manhood.

From among a variety of issues pertaining to sexuality and SSR, the investigation finds that the existing approaches are restrictive, focusing on women, the care to be taken of their body, pregnancy, menstruation and how to sexually please their partner. Education is characterized by reservations and taboos, which is why sexuality in general and SSR in particular are aspects that are little discussed within the family and when it does happen the issues raised are characterized by taboos and much secrecy.

What can be inferred from the above presentation is that generally speaking local teachings and knowledge on SSR are repeated across generations. The "permissions" and "prohibitions" illustrate the community's rationality with respect to perceptions, interpretations of issues relating to health and illness and what is culturally acceptable or not, in short: it illustrates how communities construct their perceptions about life and death. It can be concluded that initiation represents a moral and cultural pedagogy of sexual, reproductive and married life for the social groups from the localities that were investigated.

The main stakeholders at community level are the godfathers, godmothers and matrons of the initiation rites, the "elderly", the traditional and religious leaders, fathers and mothers, aunts, uncles and paternal or maternal grandparents. The role of each of these stakeholders in the educational process varies according to the specific character of the teaching to be transmitted.

Teachings at school are passed on simultaneously without there being a differentiation in time or specific teachings for boys and others for girls. The main stakeholders are the pupils and teachers, while the role of NGOs in creating an activist approach to SSR is not being felt.

The communities have the traditional and the formal health systems and people simultaneously resort to one or the other of these systems while looking for health care. The logic that guides these choices is associated with the proximity of the place where these services are available and with beliefs and perceptions of the effectiveness of the treatment or cure that can be obtained in each one of these systems.

The relationship between the three spheres of education proved to be fragile and in some cases fraught with a communication void, because the contents of the teachings contradict one another. In addition, taking into account that traditional education constitutes the primary socialization while education by the school and the health unit constitute the secondary socialization, there exists no continuity between these two moments and they do not complement one another. The investigation revealed that the entry points for improving SSR at community level are the godfathers, godmothers, matrons and persons in charge of heads of the initiation rites,

paternal uncles and aunts, paternal grandparents, ACSs, activists, religious leaders and practitioners of traditional medicine, and these actors should be involved by capitalizing on the networks within the community.

VIII. RECOMMENDATIONS

FACILITATING FAMILY INVOLVEMENT AND DIALOGUE AMONG THE GENERATIONS ABOUT SEXUALITY AND SSR

- Facilitate dialogue between the generations about sexuality and SSR through the development of programmes that mobilize and focus on enabling families to reduce the communication gaps. The lack of parental knowledge about the themes and issues that their children are exposed to through the school and friendship networks, as well as the growing disinterest of children with respect to certain teachings of the elderly might be subject of active programming aimed at reducing the communication gap between the generations. The programmes targeting youth should not only seek the consent of their parents, they should give priority to their involvement so that the parents can contribute as a social basis of reinforcement and effective guidance for adolescents and youth.

STRENGTEN AND IMPROVE THE COOPERATION AND INTERACTION BETWEEN THE VARIOUS EDUCATIONAL SPHERES

- Develop programs that increase efficient relationship forms between the traditional and formal systems of teaching and learning about sexuality and SSR issues, involving the various key stakeholders from the educational process in conceiving integrated programs.

- By means of a socio-cultural approach facilitate the dialogue about knowledge between the three educational spheres (community, education and health) in order to allow for the joint planning of adequate activities around SSR education for youth.

- Facilitate the integration of the various systems and mechanisms for teaching about sexuality and SSR by establishing and enhancing the links in ongoing programmes with the existing forums for community participation (e.g. School Councils, ZIPs, AMETRAMO, initiation rites, etc.).

- Strengthen the role of NGOs, facilitate and mobilize the intervention of OCBs in order to stimulate leadership and activism of youth and adults in approaching sexuality and SSR. NGOs can play an important role in mediating between the different spheres, taking into account their relatively neutral position in the education of youth, as compared to the school which is both formal and competitive, and the family which is seen as conservative and reprehensive.

ABOUT POSSIBLE ENTRY CHANNELS FOR STRENGTHENING EDUCATION ABOUT SSR

- Use the existing players in the three educational spheres, i.e. the community, education and health, to consolidate the gains and lessons learned in the practice of education about sexuality and SSR.

BROADEN THEMATIC OPPORTUNITIES AND REDUCE CONFLICTING CONTENTS

- Expand approaches to sexuality and SSR by introducing themes such as multiple and concurrent partners, gender-based violence, gender equity and equality, fertility and infertility (male/female) and safe motherhood.

- Develop programmes that capitalize on the existing spaces where youth socialize and that encourage dialogue and discussions on subjects related to sexuality, SSR, attitudes and safe sexual conduct.

- Sensitize the persons in charge of initiation rites so that this educational moment is used to make youth aware of the message that encourages them to delay sexual and reproductive activity and avoid premature marriage.

INVESTIGATION AND DOCUMENTATION OF EXPERIENCES AND BEST PRACTICES

- Promote and encourage research that catalogues experiences, best practices and lessons learned from ongoing interventions in the country and the region, with a view to inform and improve programmes about sexuality and SSR.

GENDER APPROACH AND FACILITATION OF ACCESS TO SERVICES

- Develop programmes that implement and encourage actions to mobilize traditional leaders and existing community organizations for conducting campaigns on gender, SSR, HIV and AIDS, with emphasis on acceptance, the demand for and use of health services by male youths and men in general.

- Promote the expansion of adolescent and youth- friendly services and implement actions to facilitate their acceptance, the demand for and the use of these services by adolescents and youth.

MULTISECTORIAL APPROACH

- Strengthen the inter- and multi-sectorial approach to capitalize on existing capacities in the MINED, MISAU and MJD.

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