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# Sexual Education for Youth in Rwanda: A Case Study of Methods, Effectiveness, and Response at the Kimisagara One Stop Youth Center

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*SIT Study Abroad*

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Sexual Education for Youth in Rwanda:  
A Case Study of Methods, Effectiveness, and Response at the  
Kimisagara One Stop Youth Center

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SIT Rwanda: Post-Genocide Restoration and Peacebuilding  
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Spring 2013

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This family has made my stay in Rwanda the best that it ever could have been—I truly feel that I have a family here in Rwanda.

## **Abstract**

In examining the increasing influence of states in contemporary society, this paper explores the concept of biopower, particularly in the area of sexual health, as a critical control mechanism that solidifies state legitimacy. By turning control mechanisms inwards, into minds and physical bodies, the state utilizes its monopoly over the legitimate use of symbolic violence to convince citizens of the assumed universality of structures and mindsets that solidify state power. Reproductive health has emerged as a crucial site of consolidating state control, perpetuating the assumed necessity of state regulation of bodies for the betterment of the nation. In Rwanda, with a need for a secure, controlled country in the aftermath of the 1994 genocide, myriad programs developed to promote these state priorities. This paper examines the impact of the state on reproductive health programs in Rwanda, using a Ministry of Health-sponsored youth center called Maison des Jeunes de Kimisagara as a case study. It attempts to review the purposeful choices made about what information to distribute regarding sexual and reproductive health and the resulting impacts of those choices.

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## **List of Acronyms**

ABC: Abstinence, Be faithful, use a Condom

AIDS or SIDA: Acquired Immune Deficiency Syndrome

CNLS: National AIDS Control Commission

HIV: Human Immunodeficiency Virus

ICT: Information, Communication, and Technology

IUD: Intrauterine Device

MJK: Maison des Jeunes

VCT: Voluntary Counseling and Testing

## **Background**

The Rwandan genocide of 1994 completely devastated the country, leaving more than 800,000 people dead and absolutely decimating the economy, the government's legitimacy, and the physical infrastructure. In the wake of such a destructive tragedy, the Rwandan government took control of the struggling nation, and under the new president, Paul Kagame, it began the slow process of rebuilding. The resulting efforts emerged in the form of fast-paced development, the current conceptualization of these efforts outlined in the government's Vision 2020 development plan for Rwanda. The plan ventures to make Rwanda a middle-income country by 2020 through establishing good governance and a capable state, moving towards a market-oriented agricultural sector, developing the private sector, improving human resources development, strengthening infrastructure, and building regional economic cooperation (*Rwanda Vision 2020*). Evident in Vision 2020, and other similar policies, the government of Rwanda has made strengthening the state and enhancing government legitimacy top priorities as a reaction and solution to the horribly fragmented and delegitimized reality of post-genocide Rwanda.

## **Bourdieu's Definition of the State**

As the state reinforces itself through various programs and institutions (like Vision 2020), it simultaneously solidifies its hold over what Bourdieu calls "the legitimate use of symbolic violence." He claims, "These processes of unification of a territory and people through a concentration of the means of violence and through a national economic market are paralleled by a concentration of 'symbolic capital.' The processes... become operative only as they obtain recognition and hence legitimacy" (Swartz 10). In other words, as a state gradually concentrates various types of capital within its territory, the resulting structures gain legitimacy, hence



reinforcing the legitimacy of the state. The unification under state structures allows the state to monopolize symbolic capital and strengthens the state's role as the holder of the legitimate use of violence (Swartz 16). In unpacking his definition of symbolic violence, Bourdieu means to say that solidification of the state gives legitimacy only to that state's particular concentration of capital, giving it power over physical as well as symbolic capital.

Because of the state's resulting monopoly over symbolic violence, all of the state's structures are assumed to be universal and for the public good. This includes control over mindsets or ideas: “[Bourdieu] emphasizes the impact of state power upon mentalities. He argues that the state imposes cognitive, taken-for-granted assumptions, classifications of the social world that encourage taken-for-granted acceptance of the social order” (Swartz 15). Essentially, the state claims universality and legitimacy for the structures, assumptions, classifications, and particular social order it imposes on a territory. He considers this the “effect of universality,” and because of it, he terms the state “the central bank of symbolic credit” (Swartz 6, 19). As the bank of symbolic credit, the state exerts its domination of legitimacy over all of its structures and convinces its citizens that all state concentration—physically or symbolically—is universal and for the public good.

### **Symbolic Violence and Biopower**

One way in which states have exerted their monopolized use of symbolic violence is through Foucault's concept of biopower. Biopower works in the sense that the legitimacy of the state is so ingrained into citizens—under this symbolically violent assumption that the state's structures are universally good—that citizens actually bind themselves in accordance with the state. Summarizing Foucault's thoughts: “Biopower does not operate in accordance with the symbol of the sword—the symbol of the sovereign—and the right to ‘*take* life or *let* live.’”

Rather, it is a ‘way of acting upon an acting subject or subjects by virtue of their acting or being capable of action’” (Brigg 4-5). Rather, the state’s monopoly of symbolic violence causes citizens to internally subject themselves to the will of the state, not a sovereign power controlling bodies directly by taking or giving life. Basically, the genius of the state is that in using its control over legitimacy, it causes subjects to internalize state values and structures as the norm, often requiring very little direct physical violence from the state to keep people in line with its proposed social order.

Foucault’s theory of biopower aligns with Bourdieu’s belief in the state’s ability to have power over mindsets. Foucault says that biopower is a “power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them” (Brigg 5). Again, the symbolic violence of the state exists in the reproduction of mindsets, specifically ones that tie bodies to the state in the internal thought processes of its citizens. The existence of biopower as a form of control allows the control mechanisms to turn inwards, on the citizens themselves. Hence, in the minds of its citizens, the state is able to exert control over bodies without using any directly physical coercion.

This control mechanism and state solidification does not only happen in the mind but on the physical bodies as well. In exploring the preoccupations of famous philosophers Foucault, Agamben, and Negri, authors Rabinow and Rose state that part of biopower consists of “regulatory controls, a biopolitics of the population, focusing on the species body, the body imbued with the mechanisms of life: birth, morbidity, mortality, longevity” (196). In other words, the state seeks to exert its control over even the physical bodies of its citizens—its “species body”—and thus it becomes preoccupied with population control and being knowledgeable of individual life and death. Rabinow and Rose also comment, “Biopower...

entails one or more truth discourses about the ‘vital’ character of living human beings; an array of authorities considered competent to speak that truth; strategies for intervention upon collective existence in the name of life and health; and modes of subjectification, in which individuals work on themselves in the name of individual or collective life or health” (195). Similarly, a state’s citizens become involved with the maintenance of their individual bodies and the collective health of the nation in a process that solidifies state control. This preoccupation, despite being internal and individual, further strengthens the state body.

### **Biopower and Reproductive Health**

Consequently, states are concerned with the reproduction of their populations, and structures emerge which enable greater state control over these bodies—again, all for the good of the nation and presumed to be universally necessary. Within these developments arise “concerns about the impact of population growth on economic wealth and the need for governments—especially those of less developed states—to introduce policies to curtail reproduction—especially among the poor—as a prerequisite to modernization” (Rabinow and Rose 209). Essentially, the rights of individual bodies become the state’s prerogative as issues like reproduction and population growth are seen as increasingly influential in state matters, like accumulating economic wealth. Again, the measures a state puts in place for controlling these issues of reproduction are assumed to be necessary for the health of the state.

More specifically, states curtail population growth by developing birth control methods, a process of state reinforcement seen as bettering the nation. Rabinow and Rose describe the historical process of this solidification over bodies through controlling population growth and reproduction: “Fundamental to [the state’s] prescription to avert this problem was birth control to

stabilize population, by limiting family size to two children, especially in those countries where it currently greatly exceeded that” (209). Citizens impose these policies of birth control and limiting family size on themselves, feeling that these measures are best for the state and its people. The actual necessity or usefulness of these efforts is irrelevant to the point: they still serve to solidify the state.

Furthering the legitimacy of this increasing control over reproduction, these measures began to fall under the requirements for modernization, as alluded to above. James Ferguson points to this desire to adopt universal “packages,” considered necessary for a developing nation to become a modern one: “Modernity figured as a universal telos, even for the most traditional of societies. And the extent to which societies differed from the modern (and, implicitly or explicitly, Western) ideal neatly indexed their supposed level of development toward that ideal” (167). Rather, even traditional societies were supposed to assume these mindsets and structures, often including this same sense of control over reproduction, in their sought-after position of becoming a modern nation. Because the dynamic between biopower and individual reproductive choices became a part of modernization, it proved difficult to pursue any other attitude except the one proscribed by the modernizing state. Thus, the desire for modernity strengthened the perceived necessity of state control over the population.

### **Rwanda’s National Reproductive Health Policy**

International thinking on reproductive health was compounded at the International Conference on Population and Development (ICPD), held in Cairo in 1994 (*Reproductive Health Policy* 1). Reproductive health is thought to include:

“The rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as

well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant” (*Reproductive Health Policy 1*).

In essence, the area of reproductive health care arose in order to monitor these aforementioned rights of citizens to choose how they want to regulate fertility, all in the name of state interest—again, the assumed right of the state to control bodies.

Western and Central Africa first defined reproductive health concerns at a Regional Forum in 1996 and made further adjustments to expand the definition in 1998 (*Reproductive Health Policy 2*). Rwanda in particular developed its policy in various phases, notably changing the Mother and Child Health and Family Planning department in the Ministry of Health to the Reproductive Health Division in 1998 (*Reproductive Health Policy 2*). The current strategy on reproductive health for Rwanda is outlined in the national *Reproductive Health Policy* from 2003.

The policy emphasizes six components: safe motherhood/child health, family planning, prevention and treatment of genital infections and AIDS, adolescent reproductive health, prevention and management of sexual violence, and social changes to increase women’s decision-making power (*Reproductive Health Policy 2*). Rwanda adopted these priorities in “its global poverty reduction strategy for sustainable development, national population policy for sustainable development, and national health policy” (*Reproductive Health Policy 2*). It is important to note, once more, the connection made between state-regulated population control—state control over bodies—and sustainable development plans. Improvements in these areas are meant to improve the country’s overall economic development and livelihood, providing legitimacy to the state’s increasingly tightened control over its nation’s bodies in the area of reproductive health.

Sexual education is obviously an area in which state priorities within reproductive health manifest. Various projects across the country—with a particular focus on the VCT (Voluntary Counseling and Testing) Services at the Maison des Jeunes youth center in Kimisagara for this report—build on these ideals and primary concerns coming from the Ministry of Health. Thus, these centers appear to be crucial areas in which to study the effects of reproductive health programs that serve to solely implement the state’s priorities.

## **Introduction and Objectives**

The Maison des Jeunes (MJK) sits in a valley between the jumbled neighborhoods of Cyahafi and Kimisagara, tucked between piles of crumbling homes as the centerpiece of a bustling community in Kigali. A place where young and old congregate, primarily to watch pick-up soccer games on the center's dusty soccer field, the center is able to provide myriad services to what appears to be a poor, struggling area in contrast to the bright and prosperous city center of Kigali. While the center targets youth, defined in Rwanda as those aged 14 to 35, its convenient location allows for many other age groups to participate in the center's services as well; orphans and young children lacking enough money to go to school pass their days playing sports at the center, struggling youth attempting to save enough money to continue school use the center as a popular hang-out spot, surrounding neighbors have the center's services at their doorsteps, and older folks come to watch free soccer in the evenings. MJK's placement in the middle of a lively neighborhood allows the center to provide services to a wider range of people and targets an impoverished area where services may be needed the most.

The youth center at Kimisagara provides a variety of services including myriad entrepreneurship and ICT workshops, classes to learn English or traditional dance, opportunities to participate in a multitude of sports including soccer, volleyball, and basketball, and particularly, services geared towards providing awareness and reduction of HIV/AIDS. The voluntary counseling and testing (VCT) office opened just last year in 2012 and provides free HIV counseling and testing to youth, couples, and adults. I choose to focus my research within this VCT sector of the center as a way to study Rwanda's approach to reproductive health and sexual education for young people.

My primary research objectives are as follows:

- To broadly examine the sexual education program and related services offered at the Maison des Jeunes de Kimisagara (MJK),
- To research how government literature and policy on sexual and reproductive health in Rwanda impact MJK's choices in what is included in the center's sexual education services,
- To analyze gender dynamics implicit within sexual health literature and policy from the Ministry of Health,
- To explore the impact of the choices made to focus on certain topics of sexual health over others at MJK—what is emphasized? What is left out? Why?
- To gain a better understanding of how young people receive MJK's services and interact with the material at the center, and
- To evaluate the continuing challenges for sexual and reproductive health programming in Rwanda using the Maison des Jeunes as a case study.



## **Methodology**

I conducted my research within a four-week period starting from April 8, 2013, and ending May 4, 2013. To gather information, I used a variety of different formats, including participant observation, semi-structured and unstructured individual interviews, a semi-structured group interview, written literature provided by the Maison des Jeunes, government policies, and other secondary sources. I worked primarily at the Kimisagara One Stop Youth Center (or La Maison des Jeunes de Kimisagara—MJK), a center meant to encourage youth from the area to participate in entrepreneurship trainings, ICT trainings, English classes, and free HIV counseling and testing by providing different sports and activities to attract young people. I spent about two weeks of the four-week research period at the center, observing their daily activities and speaking with various staff, volunteers, and attendees.

After the center's director granted me permission to spend time at MJK, I first attended the weeklong soccer tournament hosted at the center. Because the youth in the area were on vacation at the time, the center held a soccer tournament during their last week before school resumed. Boys aged 14-25 formed teams based on age and competed against each other at the MJK soccer field. MJK also provided uniforms, balls, volunteer referees, and announcers. I spent much of the first week simply getting involved in the tournament—watching from the sidelines with all of the young spectators, listening to the announcements during the games (translated one day by a host sister), and establishing a presence at the center. I paid particular attention to the announcements because the volunteer young men gave intermittent messages to the crowd about getting free HIV testing and participating in MJK's ICT and entrepreneurship trainings. I wanted to hear what all of the many spectators heard when attending a match at the center and whether attendees could learn anything about sexual health while watching the game.

After recognizing a significant language barrier, I decided to hire a translator for a day to help me with two interviews with staff members—first with Gisele Mukandayambaje, one of the center’s counselors, and then with Seraphine Mukeshimana, the VCT Coordinator. The first, with Gisele, was about 45 minutes long, held in the VCT peer educators’ office at the center and conducted in English and Kinyarwanda with a translator. I made sure the subject understood the nature of my project and asked her permission to use a recording device. We mainly discussed the content of a typical counseling session and what she as a counselor understood about youth’s relationship to sex and sexual health.

The second interview, with the VCT Coordinator Seraphine, lasted about 40 minutes and took place in her office at the center. Even though the subject spoke beginning to intermediate English, I asked the translator to join us so that the subject would have an easier time understanding and answering questions. I made sure once again that the interviewee understood the nature of my project, and she gave me permission to use her full name in my research as well as to use a recording device. We broadly discussed the services offered at the center and her impression of the reception of those services, not delving deeply into many of the issues since the subject emphasized that her role was to coordinate, not to be knowledgeable of details.

I also attended a debate held on a day during the soccer tournament. The center invited two teams of students, five boys on each side ranging from 12 to 22 years old approximately, to debate the usefulness of condoms. The center hung a flier at MJK announcing the opportunity to debate about condoms, and the ten boys voluntarily participated. The young men sat across from each other in a large room at the center’s VCT building while a few MJK staff members facilitated the debate. One side argued against the use of condoms while the other side argued for their use. I listened and had their statements translated from Kinyarwanda into English,

taking notes but not using a recording device. Since the young men mostly reiterated lessons taught at Maison des Jeunes regarding why condoms are important, at the conclusion of the debate, I requested to talk to the youth myself. I took the place of the MJK staff members as they left the room to discuss the results of the debate, and I explained my research project through my translator and requested to ask them a few questions. I received consent from those over 18, and I tried to be incredibly clear that I could only use comments in my research from 18-year-olds and above, although I was willing to listen to others who were younger. I ensured them that I would not be using their names in my report, just noting their ages—I thought it was less crucial to include specifics in order to hint at a more general mindset of young men who come to the center. In a semi-structured group interview type setting, the young men listened to my questions attentively and provided information that helped me gain insight into how sex is viewed by these boys in particular. When each boy spoke, I asked his age, to ensure the age of consent, although the younger boys spoke as well. I pointedly set my pen down whenever a younger boy stood and spoke, worried about finding adequate means of consent with no parents present. I asked a variety of questions dealing with their views on the services at MJK, how MJK's literature has shaped their attitudes about sex, and what they think about young people having sex in general.

I also attempted to interview a doctor or someone working more closely within the Ministry of Health to better understand how literature and certain topics about sexual health were chosen for nationwide dispersal. However, the doctors either proved impossible to reach or unable to meet in a timely fashion. I regret not having the time to pursue this avenue further for greater in-depth information, especially to explore the decisions made by the Ministry of Health, and acknowledge this gap in my research.

Similarly, I wanted to attend a day of Mobile VCT, hosted by Maison des Jeunes, in which the bulk of the center's staff travel to a secondary school to disperse information and voluntary counseling/testing to students. Yet, the program fell beyond the timeline of this project, another regrettable limitation.

In addition to verbal information, I worked with a translator to review some of the literature dispersed at MJK so that I could gain better insight into what knowledge the youth in the area received from the center about sexual health. I had the translator skim several booklets, focusing mainly on a CNLS brochure called *Icyegeranyo cy'ibibazo n'ibisubizo kuri virusi itera SIDA n'indwara ya SIDA mu Rwanda* (a brochure about AIDS), and also had a host sister translate the pamphlet about condom use distributed upon entering a counseling session at MJK. I also perused the Ministry of Health's *National Manual for Adolescent Sexual and Reproductive Health in Rwanda*, available at the center, and the *National Reproductive Health Policy of Rwanda* from 2003 to learn about the teaching methods and topics chosen to inform youth about sexual health and the priorities in reproductive health within the Ministry of Health. Both were written in English so I did not require a translator. The most interesting literature proved to be two booklets, one called *Inshuti Nyanshuti* ("Real Friend") and the other called *Twubake Umuryango Uzira SIDA* ("Let's Build a Family with no AIDS"), written in the form of comics. I worked carefully with the translator to understand each story and lesson of the colorful comics because I noticed many young people in the center nonchalantly skimming these booklets. Due to this observation and to the comics' easy-to-read, short and simple lessons, I thought that they might be a critical source of knowledge about sex for young people.

I complemented my primary work at MJK with an interview at a nearby clinic called Gitega Health Clinic. I wanted to find out more about the other methods available, encouraged

by the Rwandan government, that were not offered at the Maison des Jeunes; in interviews at MJK, subjects informed me that if a young person came asking for a service not available at the center, the counselors and peer educators would send them to a nearby health clinic. I sought out Gitega Health Clinic, about a twenty-minute ride from MJK, and after going through several offices, I managed to speak with a nurse named Thacienne Uwambayingabire who worked in the family planning office. We spoke privately in her office, with a box full of contraceptives next to us—which was incredibly helpful in communicating since I could easily point to each specific method to ask about details. Using our mixed knowledge of French and English, we communicated the best we could, often reverting to pen and paper to write down phrases that were not being understood verbally. Much of the notes I have from this unstructured session are in the form of written notes, by the nurse herself and in French. I thus want to acknowledge my limited knowledge of French in working to translate her notes. Yet despite the language barrier, I managed to hear some fascinating information about contraceptives available and her opinion on young people and women using them.

I also had the idea of organizing a women’s focus group outside of Maison des Jeunes to hear directly from young women about their attitudes about sex and their opinions on the literature offered at MJK. However, in approaching several women with whom I have become close over these past few months, I found that talking about sex in front of other women for many women in Rwanda is highly uncommon and quite uncomfortable. I realized that having a focus group would prove extremely difficult since the women I asked to participate kindly declined. This in itself is useful research, though, as it shows the unwillingness of many Rwandan women to speak about sex and related issues, among each other and to outsiders.

To the best of my ability as a first-time ethnographic researcher, I tried to uphold the ethical procedures for using human subjects in research. I always explained who I was, the purpose of my project, and how I wanted to record the conversation. I informed subjects of their right to remain anonymous and to skip any question they like. They knew that I would destroy the recordings after writing my report and that I would offer a copy of my final report to the center and to anyone else who wanted it. In following SIT's policy of ethics and the requirements of various federal agencies and scholarly associations regarding the use of human subjects in research, I strove to respect, protect, and promote the rights and the welfare of all those affected by my work.

I acknowledge that in my role as researcher, my personal bias and background may have influenced the answers I received from interviewees. I want to note that my identity as an American may have altered responses, especially due to the United States' relationship with the government of Rwanda. I sometimes felt that interviewees simply reiterated the information provided by the center (and hence, by the government) and did not feel comfortable sharing thoughts that were not entirely in line with the government literature.

Similarly, I began this project with a weighty assumption: in my view, sex is a normal, healthy act, when done safely and responsibly with lots of communication for all involved. Thus, I feel that an effective sexual education should fall in line with this attitude about sex—an opinion that I know impacted my analysis of findings. I tried the best that I could to simply listen and record what I heard and read during the research period but undoubtedly, my personal opinion on sexual education influenced this project.

I recognize, too, that my research had certain limitations, mainly due to time and geographical constraints. Because I only conducted my research in or around the Maison des

Jeunes de Kimisagara, the opinions I heard may not reflect nation-wide attitudes. I therefore acknowledge the difficulty and limitations of making broad assumptions based on my findings at this single site.

My main struggle in conducting this research project was finding an advisor and interviewees comfortable enough in English to answer my questions. No one in the VCT Services office spoke fluent English so finding an advisor with whom to discuss academic questions and concerns regarding the project proved difficult. I tried several times to meet with English-speaking doctors within the Ministry of Health to inquire about possible advising but those contacts fell through.

Furthermore, because of the nature of my project and the fact that discussing sex is still difficult for many in Rwanda, I understand that much might have been left out. I heard a lot of regurgitation of government (via the center) literature and not a lot of personal views on sexual health issues. I also struggled finding interviewees in general who were comfortable with and/or passionate about discussing sex with me. Coming from an environment in which many people often discuss sex (or at least more openly there than they do here), I was not expecting to have so much difficulty in hearing personal opinions about sex. However, that realization in itself proved useful to my project.

## Findings and Analysis

Rwanda has made incredible strides in promoting reproductive health issues and prioritizing these issues in the government's current development plan, manifest in their recent policies within the Ministry of Health. As outlined in the most recent *National Reproductive Health Policy* of 2003, the nation wants to focus their current and future efforts on six primary components: safe motherhood/child health, family planning, prevention and treatment of genital infections, adolescent reproductive health, prevention and management of sexual violence, and social change to increase women's decision-making power (*Reproductive Health Policy 2*).

Centers like Maison des Jeunes in Kimisagara take these government priorities and implement them as best they can in the areas in which they are operating—in effect, maintaining and strengthening a centralized program of sexual education. Through various interviews and observations, I found it difficult to find Rwandans actually passionate about sexual education and mainly spoke with people interested in upholding the government priorities on sexual health. In speaking with the VCT Coordinator at MJK through a translator, I heard that the center's "role is to distribute [and] to implement the decisions from the government of Rwanda, like the Ministry of Health, like CNLS.... [Our] role is to distribute those pamphlets and brochures. [We] aren't involved in making [the] decision of what is written in those pamphlets" (Mukeshimana). In fact, she felt that the information in those pamphlets on sexual health was sufficient and nothing was lacking or left out, despite my unvoiced disagreement (Mukeshimana). Thus, it appeared that many working in sexual health simply follow the government policy, with little thought to changing or improving the strategies or priorities.

Despite the unwavering support of these government priorities, I found that many areas in the Ministry of Health's sexual education still lack a critical approach in examining the persisting



barriers to an empowering, healthy sexual health program, including the persevering association of sex with guilt, the lingering tensions between modernity and tradition, the continual disempowerment of women struggling with modern and traditional values, and the repeated emphasis on male-dominated sex.

### **Guilt and Sex for Pleasure**

In conducting research, I found that many forms of sexual education (pamphlets, government policies, MJK staff) framed sex in a negative way that inherently discourages healthy sexual relationships and causes feelings of guilt for participating in any sexual acts. The current approach to sex for youth, advocated by the Ministry of Health, is to follow four steps, outlined in a CNLS brochure distributed at MJK. The first is to have the respect to listen to your parents and abstain from sex (*uburere*); then is to have sex only after marriage (*kwifata*); third is to not cheat on your husband or wife (*ubudahemuka*); last is to use a condom (*agakingirizo*) (CNLS, *Icyegeranyo*). This approach, also commonly called ABC (Abstain, Be faithful, use a Condom) or abstinence-only sexual education, views sex as the last step in a line of failures. If a young person ignores their parents, has sex before marriage, or has multiple partners, his last resort is to use a condom, presenting condoms not as a helpful tool but as a last option. At MJK, the common phrasing is that youth should use condoms if they “fail” to wait for sex. When asked about the advice she gives in VCT counseling sessions, counselor Gisele said, “In case they fail to handle themselves, they can use condoms” (Mukandayambaje). Even the brochure intended to encourage condom use, handed out at each counseling session, clearly stated that one should use condoms when he cannot abstain (CNLS, *Agakingirizo*). With this attitude, I would imagine that youth feel immensely guilty asking for condoms, producing a counterproductive

result if youth fear to protect themselves because of the negative language used in sexual education.

This very sentiment arose at the MJK debate on the usefulness of condoms. When asked in an informal session after the debate about whether young people were having sex, the group of ten young men all answered with a resounding “No” (Youth debate). The group wanted to make it clear that they, themselves, do not have sex, despite all having girlfriends. They expressed their need to wait until they are 21 years old, the legal marriage age in Rwanda (Youth debate). Although I can only make educated guesses, their statements made it sound like they did not want to be associated with having sex; they even blamed it all on girls at one point, saying that young girls in short skirts are the ones having sex, not young men (Youth debate). Of course, they were making their comments at a center that emphasizes waiting to have sex until marriage, and that may have impacted their answers.

Not only do boys appear to feel ashamed about wanting or “playing” sex, staff at MJK say young girls struggle with this negative association as well. According to Gisele in VCT services at MJK, not many girls come to get tested for HIV at the center “because the girls have the inferiority complex to come and get tested. Always they think that in case they find that I am HIV+, they will think that I had sex with someone” (Mukandayambaje). While this will be a topic of further discussion later in the paper, it shows that many young women also feel guilt and shame for being associated with having sex. Perhaps because the literature and information about sex portrays sex as a failure to adhere to the abstinence-only and waiting-until-marriage approaches, many young people appear to feel guilty for having sex, making it harder for them to seek help or information about how to have safe sex.

Notably, Rwanda's sexual education does not emphasize on building and maintaining healthy sexual relationships but on dispersing information about the negative effects of sex and the consequences of failing to follow the government-approved steps—mainly HIV/AIDS and unwanted pregnancies. So much of the literature and many of the responses from MJK staff point to an exclusive focus on HIV and “abrupt” pregnancies, further discouraging the possibility of guilt-free, safe sex. In fact, the primary purpose of the Maison des Jeunes is to test for AIDS, a priority chosen for these centers that disperse information to youth about sexual health that arguably creates negative associations with sex. The MJK counselor explained, “The kind of information that [the center] always give[s] to young girls is how they can prevent HIV/AIDS. That is specifically what [we] emphasize, preventing HIV/AIDS. [We] teach them also... the other ways: that you have to save yourself until you get married [and] in case you failed, you use a condom” (Mukandayambaje). In other words, the center chooses to identify sex as a bearer of negative consequences rather than as a pleasurable act in itself. Sex is viewed simply as a way in which one may contract AIDS; in other literature, sex is only for reproducing children, when ready. Even the term “sexual health” is not used in government literature, instead favoring “reproductive health” that focuses on preventing HIV/AIDS, spacing pregnancies, and raising healthy children—none of these associations include sex solely for pleasure.

In focusing on sex associated with HIV/AIDS and unwanted pregnancies, in treating condoms as a failure to follow the steps to having safe sex, and in using language that perpetuates feelings of guilt around issues of sex, the priorities of the government's sexual health education appear to deal more with preventing negative, unwanted consequences than encouraging positive, guilt-free, and safe sexual relationships. This attitude of sex may have

some roots in Rwandan culture, as evidenced in various interviews, and points to an interesting dynamic between modern and traditional values.

### **Modern vs. Traditional: the Literature**

Manifest in Vision 2020 and many of the government's recent policies, the Rwandan government strives to shape its nation into a developed, increasingly modernized country—the model city for development in East Africa. Their progressive changes in the *National Reproductive Health Policy* align with this vision of a modern Rwanda: significantly increasing the use of modern contraceptives, reducing the number of AIDS cases and providing ongoing support to those currently living with AIDS, strengthening adolescent reproductive health programming, and empowering women through programs aimed to keep them in school (*Reproductive Health Policy* 17-21). Despite these progressive changes, the sexual education literature of Rwanda continues to highlight an ongoing tension between the modern plans and traditional values.

Two government-sponsored pamphlets distributed at Maison des Jeunes, called *Twubake Umuryango Uzira SIDA* (“Let’s Build a Family without AIDS”) and *Inshuti Nyanshuti* (“Real Friend”), manifest a distinct tension between this popular push for modernization and lingering ties to cultural values, of which some appear contradictory to modern aims. Both booklets distribute information in the form of bright, easy-to read comics, and I often observed young people reading them while waiting in VCT Services at MJK. Thus, they appear to be a common source of knowledge for young Rwandans in the area about sexual health issues, and they impart attitudes about the divisions between modern and traditional and urban and rural in regards to sexual health.

Particularly, these comics point to a continuing rift that exists between rural and city life, especially in terms of sexual education. In *Twubake Umuryango Uzira SIDA*, the characters Alice and Robert, a couple presumably living in the city, discuss whether or not they should have sex and compare their situation to Robert's brother's life in the rural countryside. The comic shows Robert's brother surrounded by five children very close in age outside of a rural hut. Robert's brother has to constantly ask for money to send his children to school and feed his family, unable to sustain his large family on his meager earnings (*Twubake Umuryango Uzira SIDA* 7-8). Robert reminds his brother of the government's encouragement to only have as many kids as you can support and to use family planning to space out your children, reiterating the Ministry of Health's message of promoting modern family planning methods (*Twubake Umuryango Uzira SIDA* 7). Yet a simple projection of these modern methods into rural life in Rwanda overlooks crucial components that may make this implementation difficult. Why are rural families having more children? What difficulties may arise when introducing family planning methods into rural communities? What efforts can be made to ease the acceptance of these changes? While further analysis of this concept digresses from the main point of this paper, it is important to note the tense dynamic between rural and urban and the lack of attention given to it.

In the same comic, Alice voices an interesting connection between culture and sex, adding to the agitated relationship between modern and traditional values. When Robert tries to convince her to have sex with him before they are married, Alice responds, "I'm ready to be a good wife, but I don't want to kill our culture" (*Twubake Umuryango Uzira SIDA* 3). Hence, being a good wife means pleasing her man, which in this case means having premarital sex with him, but sex before marriage contradicts her culture. Poor Alice is stuck between pleasing

Robert and embracing a more “modern” concept of premarital sex and on the other hand, following the tradition of waiting until marriage.

Similarly, 16-year-old Gasaro in the comic *Inshuti Nyanshuti* struggles with the temptation of becoming a “modern woman” contradicting the necessity of following her culture’s traditional values. Gasaro encounters a sugar daddy named Fred—an older man who preys on young girls for sex—who, in exchange for giving her modern make-up, short dresses, and money, convinces her to have sex with him. After leading the young girl to his bedroom, he asks her, “Do you want me to teach you how to be a modern girl?” and proceeds to undress her and have sex (*Inshuti Nyanshuti* 6). In other words, Gasaro’s desire to fit in with the image of a modern woman causes her to have sex with this stranger—who gives her an unwanted pregnancy and AIDS.

If the Rwandan government itself encourages a move towards modernity, why do women like Gasaro and Alice struggle so much with simultaneously respecting their culture and being modern women? And as mentioned above, why must they feel guilty for moving towards becoming modern women when that is what the government and Ministry of Health is encouraging them to do? The implications in both of these simulated situations amount to a lot of pressure on the Rwandan woman. She must feel pressure from both a modern society and men to go against traditional values; essentially, she should be embracing modern conceptualizations of sex but she should not be having premarital sex.

### **The Contradiction of the Modern Woman**

Although I am working largely on assumptions based on my month-long research observations, it appears that the concept of the “modern woman” in Rwanda is full of

contradictions. Being a modern woman under the Ministry of Health's *National Reproductive Health Policy* would mean that she should feel comfortable discussing, considering, and using modern contraceptive methods, presumably even if unmarried or under 21 years old. Albeit outdated, the *Reproductive Health Policy* from 2003 "set a specific objective to increase to at least 15% (up from the present figure of 4%) by 2010, the utilization rate of modern contraceptive methods among women of childbearing age" (*Reproductive Health Policy* 17). The implications of this policy are manifold: that she is having sex (premarital or not), that she should let a counselor, doctor, and/or boyfriend know that she is having sex, and that she should not feel ashamed to embrace family planning by using modern contraceptives encouraged by the Ministry of Health.

While the young men at the MJK debate made it sound that young ladies were the ones having sex, my research has shown that women have very few avenues to actually express a desire to have sex. Gisele, VCT counselor at MJK, pointed to culture as a main reason that girls do not engage in sexual activities. My translator interpreted: "She's saying that for boys to have sex, it's not acceptable but they are free to have sex. Yet for the girls, it is very, very prohibited. There are Do's and Don'ts. For the girls, there are Don'ts, a lot of Don'ts" (Mukandayambaje). In other words, according to Gisele, the pressure to refrain from sex—that they receive from Rwandan culture assumedly—is much less influential for the boys than it is for the girls. She also implied that many girls feel ashamed to come to the center to ask for VCT services because it means that she is admitting to having sex with someone (Mukandayambaje). Thus, a huge challenge for Maison des Jeunes, according to staff members, is that they struggle to convince young women to utilize the center's services, with the significant implication that culture hinders girls' willingness to openly admit to having sexual relations.

Also, manifest in the comics at MJK, the Ministry of Health promotes campaigns for young girls to say “No” to sex, providing little opportunity for women to say a more positive, empowering “Yes.” In *Twubake Umuryango Uzira SIDA*, Robert desperately wants to have sex with his girlfriend of two years, Alice, but the comic portrays her character as adamantly saying “No” and wanting to wait until marriage. The story of the young girl, Gasaro, in *Inshuti Nyanshuti* shows how girls should say “No” to sugar daddies when asked to have sex. The final page of the comic endorses a CNLS campaign called *Sinigurisha*, meaning, “I won’t sell myself” (*Inshuti Nyanshuti* 12). Of course, young girls should avoid having sex with exploitative sugar daddies but what general message about sex does this campaign send to women? It encourages a resounding “Oya” (“No”) to sex that can hardly give young women a positive outlook on sex. This “No” to sex attitude paired with the cultural “Don’t” of women having sex before marriage does not provide a healthy, positive perspective on sex for young ladies and, in my view, gives them little opportunity to have guilt-free, safe sex.

The government policy also implies that young women should talk about their sexual habits, which, of course, culture forbids them to engage in until marriage. Again, interviewees identified culture as a critical barrier to speaking about sex. Seraphine, head of VCT services at MJK, said, “Based on our culture of Rwanda, girls have this [way] of keeping secrets and a culture of being limited and not doing this and that. We have Do’s and Don’ts in our culture. That’s why [girls] don’t show themselves around here at the center” (Mukeshimana). Gisele, also of MJK, reiterated: “In our culture, we have a kind of keeping secrets, especially for the young ladies. For the girls, you have secrets: ‘I’m not going to talk about this and this because they are going to tell someone else’” (Mukandayambaje). Again, interviewees repeated the importance of cultural Do’s and Don’ts, one of those Don’ts apparently requiring girls to keep



their sexual habits a secret. I encountered this same mindset when I attempted to organize a female-only focus group to discuss their attitudes about sex. The women with whom I asked to speak declined my invitation to openly discuss sexual issues in front of each other and in front of me. Consequently, perhaps the implications of the government reproductive health policy may not focus enough on the cultural barrier that exists for women and talking about sex.

Lastly, in wanting to increase the prevalence of modern family planning, the policy suggests that young women should not feel ashamed for using modern contraceptives; the Ministry of Health endorses their use, and thus women should follow the policy and use contraceptives guilt-free. Notwithstanding, a nurse named Thacienne at Gitega Health Clinic commented, “Actually, the young people... use contraceptive methods like pills but their number is still low because they think that only married people are concerned. In other words, they feel ashamed” (Uwambayingabire). It appears, then, that even at a health clinic that provides all forms of modern contraceptives for free, young people still feel uncomfortable using modern methods, especially when they are unmarried. Once more, it points to the fixation on the cultural Don’t for young people, particularly young women, to have sex before marriage; yet at the same time, it supports using modern methods of contraception, even for unmarried women. It is an unfortunate situation for young Rwandan women: they should not feel ashamed for using modern methods of family planning, but they should feel ashamed for having sex because they could not wait until the culturally appropriate age of marriage.

Admittedly, the goal of raising modern contraceptive use could be meant to target just married couples, making many of these above arguments null. But centers like MJK provide services to all youth—from ages 14 to 35, young and old, married and unmarried, male and female—and since the center follows the government’s Reproductive Health policy, the

implications of the policy impact the services given to everyone at MJK, including unmarried young women. Also, neither the policy or government manual on reproductive health mention whether the principles apply to only married Rwandans.

Consequently, the Ministry of Health's goal of increasing modern family planning methods is intended to empower women and enhance their lives (as part of the policy's broader priority of increasing women's decision-making power) yet continues to ignore restraining cultural attitudes. The modern Rwandan woman is thus trapped between the forceful pressures of tradition (not desiring sex, waiting until marriage, not speaking about sex) and modern policies (using modern family planning methods, speaking openly about sex). The policies especially require her to break down traditional gender roles in encouraging her to act more as Rwandan men do: having guilt-free safe sex (or at least less guilty), using modern birth control methods, and openly speaking about sex. However, the government-sponsored literature and interviewees' comments suggest that, in contradiction to the forward-thinking *Reproductive Health Policy*, sexual education in Rwanda actually continues to perpetuate traditional gender roles and still focuses heavily on the man.

### **Male-dominated Sex**

In addition to the contradiction of the modern woman actually serving to disempower women, it appears that other areas of sexual education continue to privilege men as well. First of all, anatomical descriptions in a multitude of government literature place emphasis on the male and not the female. For example, in the *National Manual for Adolescent Sexual and Reproductive Health in Rwanda*, the anatomy section describes the vaginal opening as follows: "the man's penis is inserted here during sexual intercourse" (*National Manual* 47). Essentially, a

woman's vagina is defined by its relationship to a man's penis, insinuating that a vagina's sole purpose is for a man's penis. A description such as that causes women to be defined by their relation to men, far from empowering women. In contrast, the description of the penis includes a lengthy explanation of how, during hetero-normative sex, the penis penetrates a woman's vagina and allows the man to reach orgasm (*National Manual* 58). Comparing the paragraph-length description of the penis to the single sentence about the vagina, it appears that, in terms of anatomy at least, the attention rests on the man.

Furthermore, birth control options in Rwanda are primarily limited to male condoms, with little knowledge of or desire to use other methods of family planning, especially those for women. The Ministry of Health, however, does promote family planning as part of their Reproductive Health Policy, which includes myriad forms of contraceptives. Listed first in the government-issued pamphlet *Twubake Umuryango Uzira SIDA* is male condoms, with a complete explanation of how to use them (6). Towards the end of the pamphlet, the authors also list other methods, reemphasizing male condoms (*agakingirizo*) and introducing a traditional method of using a beaded necklace to count the days of a woman's menstrual cycle (*urunigi*), injections (*urushinge*), IUDs (*agapira*), oral pills (*ibinini*), sterilization for women (*kwifungisha burundu*), and vasectomy (*kwifungisha burundu*) (*Twubake Umuryango Uzira SIDA* 14). Even at the Maison des Jeunes, the counselors have access to a large teaching book from the Ministry of Health with colorful pictures of all the different forms of birth control, including those listed above and adding: plastic insertions of hormones into the arm (*udupira*), spermicide (*ururenda*), the calendar method of counting the days of a woman's menstrual cycle (*kubara*), and female condoms (*agakingirizo k'umugore*) (*Kuboneza Urubyaro*). Undoubtedly, there is plenty of information available about these different methods.

However, it appears that the young people with whom I spoke knew very little about these other forms of contraceptives and only knew about contraceptives for men. When I asked the young men at the MJK debate about their knowledge of other forms of birth control besides male condoms, they took a very long time to answer and finally mentioned circumcision, helpful for preventing AIDS but not preventing births (Youth debate). It felt like a quiz, with everyone thinking very hard to come up with the right answer, and some of the young men even started flipping through the available MJK pamphlets scattered on their tables for answers. When directly asked about birth control for women, the only answer they had was female condoms (Youth debate). Thus, despite the Ministry of Health including information about various forms of birth control, the information about methods for females is clearly not reaching the young people I encountered.

According to the VCT counselor at Maison des Jeunes, the center emphasizes on condoms because the other methods are beyond their capability to distribute; they send anyone interested in other methods to seek help at a hospital or clinic (Mukandayambaje). I got the impression that young people had to pointedly ask about other methods before receiving information; in other words, the information was not openly distributed on other forms of birth control. This insinuates that a certain stigma, hesitance, and/or ignorance exists around these other methods of family planning for women, despite the Ministry of Health's encouragement to use them. I encountered this same attitude at a nearby health clinic. According to the nurse in the family planning office at Gitega Health Clinic, "Certain people say that family planning (fear of modern methods) is a sin," although she made it clear that she strongly disagreed with this sentiment (Uwambayingabire). What this implies is that other forms of birth control, especially those meant for women, are not as common or understood like the male condom. It seems that

some sort of hesitation still exists around protective methods for women, perhaps because of the aforementioned cultural “Do’s and Don’ts” women face regarding sex in Rwanda.

## Conclusion

In summarizing the above research, there are inevitably contestable areas within the government's sexual education program. Despite so much support of the government's priorities in reproductive health and the incredible progress the country has already made so far, the current program, at least at MJK, does not delve deep enough into the lingering tensions between modern and traditional values, the pressure on women in modern sexual relationships, and the changing conceptualizations of sex. Overlooking these crucial factors may end up hindering the overall effectiveness of sexual education programs in Rwanda if its citizens, especially female ones, struggle amid so many continuing contradictions. The tension between the "modern" priorities and traditionally held beliefs continues and must be further analyzed.

What does this imply about modernity? Returning to Ferguson, what is the impact when the application of a preconceived set of modern ideas produces tension with that nation's particular cultural norms? Rather, when culture is considered a barrier to modern values within reproductive health, what is going on?

This tendency to use culture as an excuse reoccurred in many of my findings. Multiple times in my research I encountered opinions that blamed culture as a reason for not being able to speak about sex or to have premarital sex, especially for women. Yet, culture is constantly shaped by people and context and by power and institutions, and is not a separate, uncontrollable entity. Culture can always change, when the dynamics between state and citizens change or when the mindsets of those in power change. More likely, it is how institutions and structures portray and control cultural norms that helps or hinders change.

Essentially, there is a reason that culture is used as an excuse to hinder progressive changes. Cultural norms that are asserted through state structures (or more specifically: through

government literature) tie citizens even closer to the state, alluding to the earlier discussions of Bourdieu and Foucault. One could claim, then, that by continuing to put limits on women—and men—even in progressing efforts towards modernization, the state hesitates to relinquish this element of control over bodies. The question then becomes: does modernization entail a loosening of state control over bodies? Should it?

While this discussion of culture and modernization deals only in vague generalizations and further analysis goes way beyond this paper, the concluding point appears to be the same. Within sexual education and the promotion of reproductive health policies, state institutions make certain decisions for a reason, with significant impact on control mechanisms of state bodies. Due to these persisting questions, Rwanda still has much work to do in its push for modernization and development within the reproductive health sector.

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