2025-10-14

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Springer Nature

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Abstract

Faced with multifaceted challenges in the area of sexual and reproductive health, such as teenage pregnancies in schools, gender-based violence, early marriages, low adherence to family planning, very high fertility rates, among many, the Burundian government has since 2007 undertook a national reproductive health policy. The policy is based on eight components, including (to focus on what is most relevant to us): family planning, prevention and treatment of abortions, prevention and treatment of STIs and HIV/AIDS, and promotion of RH among young people and adolescents, etc. However, the implementation process of the said policy remains a challenge. The ministries in charge of health and education, respectively, advocate modern contraceptive methods and sexuality education in

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S. M. Kilonzo, E. Chitando (eds.), *The Palgrave Handbook of Religion, Health and Development in Africa*, https://doi.org/10.1007/978-3-031-62891-7_35-1

schools, while some religious denominations prioritize natural methods such as sexual abstinence in accordance with their interpretation of the Holy Scriptures. This chapter therefore analyzes the contribution of religions to the public policy process, taking the culturally delicate issue of sexual and reproductive health policy as a case study. It assesses the scope of the teachings inculcated by religions and analyzes the contradiction between these teachings and the actions promoted by the government in this highly sensitive realm of sexual and reproductive health.

Keywords

Health policy · Religions · Sex · Reproduction · Family planning · Gender-based violence · Sexuality education · Burundi

Introduction

To understand the decision-making process behind the *National Reproductive Health Policy* adopted by the Burundian government in 2007, we draw on the concept of a "paradigm" developed by Thomas S. Kuhn. According to Kuhn, a paradigm is a way of thinking shared by the majority of key players in a field over a given period of time. And as long as the model holds up, all actions are inspired by it, and a minimum of consensus emerges among key stakeholders. But at some point, certain players begin to question some components of the paradigm. These initially erratic "naysayers" gradually gain ground and eventually take over. Eventually, their model of thought takes hold and replaces the previous one. It then becomes the new paradigm (Kuhn, 1970). The same applies to public policy: the social perceptions underpinning public action change over time, often in response to technological innovations (Muller, 1990).

In the context of this chapter, the sexual and reproductive health (SRH) policy "paradigm" derives from the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994. Here, participants mainly from Western liberal states were able to impose a paradigm of SRH which, for the first time, broadened the biomedical paradigm to include biopsychosocial issues. Innovations such as the SRH of unmarried people, and even of young people and adolescents, hitherto unthinkable in the "normal" way of thinking, saw the light of day and even became the norm. For example, the World Summit on Sustainable Development held in New York in 2015 (a follow-up to the Cairo one) established 17 Sustainable Development Goals (SDGs), the third of which focuses on public health in general, with Target 7 on SRH specifically. It is obviously within this mind that the Burundian Ministry of Health drew up the key components of the sexual and reproductive health policy in 2007.

Seemingly rational, the SRH's Western-inspired policy ran the risk of clashing with the profound interests of some religious traditions, since the liberalization of sexuality contravened the dogmas of the main religions: Christianity and Islam. And

since these religions have long been deeply rooted in society, their contribution to social policy in general, and to SRH policy in particular, is indispensable. This is why it is useful to analyze the contribution of these main religions to the SRH policy-making process in the light of the realities on the ground. For while religions have traditionally been inclined to rigidly prohibit sexual activity by unmarried people, they are increasingly called upon to convince their followers to make the "right choice" when it comes to sexuality: sexual activity that is open to responsible procreation. The aim of this chapter is therefore to show that the SRH policy undertaken by the government in 2007 had little chance of succeeding with programs that are perceived to be in contradiction with religious doctrine.

Brief Overview of the National SRH in Burundi

For a better understanding of Burundi's SRH policy undertaken by the Ministry of Health in 2007, it is useful to explain the complexity of the SRH paradigm inspired by the international fora by showing its components, on the one hand, and to give a brief overview of the content of this policy inspired by the aforementioned paradigm, on the other.

The Complexity of the SRH Paradigm

The SRH paradigm emerged from a series of international fora in favor of women's rights following the cultural revolution in the West in the 1970s (Inglehart, 1990). The aforementioned Conference on Population and Development held in Cairo (Egypt) in 1994 gave it particular prominence. A definition adopted by a number of organizations defending fundamental rights in general and women's rights in particular was not long in gaining acceptance. "Sexual and reproductive health" is defined as "the general physical, mental and social well-being of the human person as regards the reproductive system and its functions and processes, and not merely the absence of disease or infirmity. This implies that a person can lead a satisfying sex life in complete safety, which they are capable of procreating and free to do so as often or as infrequently as they wish. This last condition implies that men and women have the right to be informed and to use the family planning method of their choice, as well as other methods of their choice for regulating births that are not against the law..." (ICPD, 1995).

This apparently consensual perception of the SRH represents a genuine "paradigm shift"; in other words, it highlights a change between the way of thinking about the SRH that was previously in force, on the one hand, and the way that is now advocated, on the other. At least three examples illustrate these changes:

(i) Broadening the biomedical approach: Until now, health had been understood in terms of the difference between the normal and pathological state of the human body (based on scientifically identifiable standards). Here, medicine is

concerned with "the causes and treatments of health problems according to their biological origins" (Lacourse, 2020). From this perspective, the absence of pathogenic elements implies good health. In the spirit of the "sexual and reproductive health" approach, on the other hand, a biopsychosocial model is added: far from calling into question the classic biomedical model, it broadens it by taking into account new factors, in particular, those inherent in the socioeconomic and cultural environment in which people live (Berquin, 2021: 24).

From this perspective, a diptych in terms of approach can be observed for sexual health: on the biomedical side, people are subject to the same medical treatment regardless of the multidimensional environment (social, economic, cultural, etc.) in which they live. On the biopsychosocial side, on the other hand, people are specific in that they are "products" of the socioeconomic and cultural environment in which they were born and developed (Reiss, 1981). In other words, they deserve treatment that best responds to the specific needs inherent in their multidimensional environment.

(ii) Going beyond the "procreative sexuality"/"erotic sexuality" diptych: The definition speaks of a sexuality that frees a person to procreate but says nothing about the marital status of that person. Until then, it was only "procreative sexuality" that was perceived as "normal" and reserved for legally and socially constituted couples, according to the customs of most of the countries from which the participants at the Cairo Conference emerged. What is more, even the erotic pleasure implicit in the "satisfying" nature of sexuality had hitherto been conceivable only within marriage (Benoît XVI, 2023).

With the paradigm of sexual and reproductive health, however, the right to sexuality is extended to all people in the form of "human rights," commonly referred to as "sexual and reproductive rights": not only single adults, who already enjoyed these rights in practice but were perceived as deviant, but also young people and even adolescents now openly enjoy these rights. But because managing the consequences of sexual activity was proving problematic, particularly in terms of early and unwanted pregnancies, gynecological complications, such as obstetric fistula, and sexually transmitted infections (STIs), "safe sex" required the use of modern contraceptive methods. As a result, sexual activity has become commonplace, and sex outside marriage is less and less stigmatized (Uka et al., 2024).

(iii) Sexual and reproductive rights as attributes of all age groups, therefore including young people and adolescents: as the list of sexual and reproductive rights can be quite long, it is appropriate to limit the analysis to those that are relevant to this study, i.e., those that attract the attention of religions. From this point of view, two of them are of particular interest to us: the right to sexual and reproductive health education and the right to family planning.

For the right to training in SRH, young people and adolescents should receive from school the information inherent in both the biomedical and biopsychosocial paradigms. For the biomedical aspect, they should learn, through the biology course,

how transformations in the human body go hand in hand with changes in SRH. This would enable learners to master the mechanisms of reproduction and thus behave responsibly. As for the biopsychosocial aspect, they would learn about the multidimensional factors that skew SRH, such as inequality between men and women, the culture of large offspring or early marriage, gender-based violence (GBV), and so on (Bilinga, 2014).

Until now, the right to family planning has been understood to apply to "normal" couples. It is its applicability to single people, young people, and teenagers that has given rise to opposition. Indeed, the use of contraceptive methods by young people in general and adolescents in particular is perceived as a real incitement to debauchery (Mudzimu 2021). The thorny challenge is that religions and religious leaders should not turn a blind eye to the actual sexual activity of young people, on the one hand, and to the fact that despite a high percentage of faithful, the entire population does not necessarily adhere to religious precepts.

An a Priori Rational SRH Policy

As mentioned above, the ICPD in Cairo (1994) has continued to underpin international forums on health in general and sexual and reproductive health in particular. This was the case for the World Summit on Sustainable Development Goals held in New York in September 2015. Sustainable Development Goal (SDG) 3 is one of the 17 goals designed to "promote health and well-being" within a 15-year timeframe (from 2015 to 2030). It should be noted in passing that, at the level of the African Union, this SDG3 corresponds to Agenda 2063 in its aspiration entitled: "An Africa whose development is people-centred, which builds on the potential of its people, especially women and young people, and which ensures the well-being of children" (African Union, 2015).

As is almost always the case when policy directions in a specific area are decided at the level of international institutions, the States Parties use the same framework to undertake inherent policies. For Burundi in particular, the Minister of Health prefaced the SRH policy document in these terms: "*Burundi, having subscribed to the international commitments in the context of the International Conference on Population and Development held in Cairo in 1994, the 4th World Conference on Women held in Beijing in 1995, as well as the Millennium Development Goals adopted in New York in 2000, has set itself the objective of implementing these commitments through this National Reproductive Health Policy* (République du Burundi, 2007: iii). In practice, governments call on experts to 'find problems (on the national ground) for solutions (already envisaged by international institutions)'" (Naudet, 1999). In developing countries, this is made all the easier by the fact that funding is provided by United Nations agencies such as WHO, UNICEF, UNFPA, UNDP, etc., according to their respective sectors of intervention.

With this in mind, and to limit ourselves to the SRH sector, target 7 (one of eight) of MDG 3 is worded as follows: "*By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information and*

education, and the integration of reproductive health into national strategies and programmes."

In Burundi, the Ministry of Health has deepened the health policy undertaken since 2007 (Republique du Burundi, 2008) by developing SRH programs in particular (République du Burundi, 2016). These include:

(i) *Setting up national programs on reproductive health*: these include the *National Reproductive Health Programme*, the *Maternal, Neonatal, Infant and Adolescent Reproductive Health Programme*, and the *Sexual and Reproductive Health of Adolescents and Young People Programme*. Launched in 2016, these programs are in fact a further development of the various pillars of the 2007 *National Sexual and Reproductive Health Policy.* And while they all affect SRH in a general way, it is the latter that aims to raise public awareness of SRH: the issues underpinning SRH are now to be addressed not only for married couples and adults living in free unions but also and especially for young people and adolescents.

(ii) *Capacity-building for human resources throughout the health pyramid*: Having undergone training themselves, teams working at central level were called upon to train (or update) healthcare staff at central, provincial, and peripheral level in SRH. The training was aimed at healthcare workers from public, private, and faith-based facilities. Community health workers (CHWs) working on the hillsides were also trained.

(iii) *Collaboration between the Ministry of Health and national and international partners and NGOs* that already have solid experience in the field of SRH. National organizations include ABUBEF (Burundian Association for Family Welfare), the Seruka Centre (an organization providing assistance to victims of GBV), etc., whose day-to-day work includes SRH. As for international NGOs, there are CORDAID, CARE Burundi, Action-Aid, etc., which interact with a series of local associations.

(iv) *Setting up "youth-friendly health centres"*: These are intended to take in charge of the SRH of young people and adolescents on the periphery of the health pyramid. In collaboration with structures such as local authorities, primary and secondary schools, health committees responsible for the governance of public health centers, networks of CHWs in the hills, etc., on the one hand, and in interaction with private organizations such as associations, local NGOs, etc., on the other, youth-friendly health centers are expected to play a key role in the provision of SRH services for young people and adolescents. According to a report by the Ministry of Health, the youth-friendly health center "is networked with 4 neighbouring schools, each of which has a well-supervised health club that should incorporate all aspects of school health promotion" (République du Burundi, 2018).

(v) *Combining efforts against GBV*: In addition to the Ministry of Health, other ministries, such as the Ministry of the Interior (which is in charge of the police), the Ministry of Justice, the Ministry of Education, the Ministry of National Solidarity (in charge of gender issues), etc., on the one hand, and other private

organizations such as local and international NGOs, and associations, on the other hand, were called upon to combine their efforts in order to eradicate GBV. Two examples of concrete actions are the development and implementation of the Penal Code and the integration of the SRH component into school curricula. In the first case, the 2017 Penal Code benefited from the input of all these stakeholders. Further, refresher training in SRH was to be provided for the various players in the criminal justice system (prosecutors and court magistrates, judicial police officers and agents, and prison managers). As for the latter, secondary school curricula have now incorporated that dimension.

In the end, the SRH paradigm took hold at the international level, and a number of countries including Burundi, signed up to it. Subsequently, SDG 3 in general and target 7 on SRH in particular underpinned a policy that was a priori as solid as it was highly complex.

It is worth analyzing the implementation of this policy on the ground, i.e., the way in which the various stakeholders interact to translate the SRH policy into action, and more particularly the key players involved in the grassroots communities.

The National SRH Policy Put to the Test in the Field

Conceived at the central level of the Ministry of Health, national SRH policy is coherent in principle, but not without its pitfalls. This is why it needs to be assessed in the light of the facts on the ground. To do this, this section will first review the main actors in the SRH policy and then analyze the challenges hindering its implementation, in both cases paying particular attention to religious organizations and their leaders.

Stakeholders in the SRH Policy

Any public policy in general, and any policy that initiates substantial change in particular, cannot be the subject of a consensus between all the stakeholder groups. This is because the interests of the latter are either harmed as long as the policy's objectives and actions clash with their social representations or advantaged as long as the implementation of the policy is in line with their preferences (Roe, 1994). The same is true of Burundi's SRH policy. Its stakeholders can be summarized as follows:

(i) *Public-sector health professionals*: Health workers (doctors and nurses) who provide technical assistance to the population in the use of SRH services, including gynecological consultations for patients of all ages, the administration of contraceptive methods that require medical expertise, and the care of victims/survivors of SGBV, among other roles.

These are also the healthcare and non-healthcare personnel who raise awareness of the SRH policy, particularly at the intermediate (i.e., provincial) and peripheral (i.e., district and healthcare center) levels. Although these staff are theoretically supposed to defend the logic of the SSR, many of them remain attached to tradition and religious precepts. These include older people who, as parents of adolescents themselves, are actually inclined to discourage sexual activity among young people. It should be noted that health professionals (in the public sector) offering SRH services aged between 35 and 39 and 40 and over are estimated at 78% and 63%, respectively (République du Burundi, 2019). This attitude is in line with the analysis carried out by Franklin I. Onukwugha and his colleagues in other African fields: "Surprisingly, SRH service providers do not share the same view [with young people/teenagers]. Many service providers hold negative views on adolescent sexual activity, and this deters them from providing appropriate services" (Onukwugha et al. 2019; 141).

(ii) *Health professionals in faith-based sectors*: Health professionals in faith-based structures do not offer SRH services. In terms of family planning, for example, they do not tolerate sexual activity among young people and always advise sexual abstinence. According to the abovementioned survey, "With regard to the statement 'the use of contraceptives goes against my religion and should therefore not be offered to adolescents', 60% of faith-based (...) health providers agree, compared with around 30% of health providers in other statuses *[i.e.* public and private sectors]" (République du Burundi, 2018).

(iii) *Religious denominations*: Most religious leaders are dissuading the faithful against the SRH package because they believe its components go against their dogmas. Take at least two examples:

First, taking charge of the sexuality of young people and adolescents is inadmissible: according to the Bible, fornication is simply a sin (1 Corinthians 6: 18 or the 6th and 9th commandments of the Decalogue). As for the Quran, fornication is a sin of the flesh that must absolutely be avoided (Sura 17, verse 32).

Second, family planning using contraceptive methods: Although some interpretations of Christianity and Islam reject contraceptive methods, nowhere is contraception explicitly forbidden. For example, as long as conception is intended to benefit the health of the mother, it is recommended by some Catholic priests. As for Islam, "*These Muslim representations of sexuality and life authorise women to use new methods of contraception such as the coil or the pill, including the morning-after pill [...], within the context of marriage*" (Fortier, 2010). In short, religions turn a blind eye to contraception, but only within marriage! And most of the religious leaders interviewed emphasize the natural method, explaining that any sexual act within marriage must be open to procreation, hence the responsibility for handling sexuality.

(iv) *Population covered by the SRH policy*: The Burundian population, especially in rural areas, is not sufficiently interested in the SRH policy. There are two main reasons for this:

First, a culture of taboos around sexuality: Because of the taboo around sexuality, most parents do not discuss sexual issues with their children. As a survey conducted across Burundi shows "the lack of communication between parents and daughters about sexuality and menstruation seems to go both ways in that parents do not feel comfortable discussing these issues with their daughters, while daughters were often described as being 'shy' or 'ashamed' of discussing these issues with their parents" (Costenbader et al., 2021: 16). It should be noted that sex education, which used to be provided by paternal aunts for girls and uncles for boys, is no longer practiced when families break up. Teenagers are then taught by their peers with comparable skills. This phenomenon seems to be shared by several African countries, such as Uganda (Nalukwago, 2019) or Tanzania (Lice-Deroche et al., 2021). However, technological developments are giving young people access to information on sexuality (pornographic films, for example), leading to unwanted pregnancies (Bahimana et al., 2023).

Second, a culture that regards children as a divine gift hinders support for family planning: a large number of offspring is seen as a sign of divine blessing. In this respect, it is common to hear blessings addressed by older people to someone they love "Have many offspring" and common names meaning tenth (*Bucumi*), eleventh (*Misago*)... children. This means that the family planning inherent in the SRH has a hard time gaining acceptance, especially in the rural areas. Even most political leaders are not convincing when they preach family planning when they themselves have more children than the national average (5.5), hence the contradiction between political rhetoric and practice (Shwartz et al. 2022)!

Ultimately, the various stakeholders involved in SRH policy each have a particular view of it. It is this divergence of viewpoints among the players involved in a policy that makes its implementation complex, depending on the balance of power between the key players (Weimer & Vining, 2017).

Problems in Implementing the SRH Policy

According to Padioleau (1982), the success of a public policy ultimately depends on the awareness of its target publics. But this awareness in turn depends on the realization of a gap between the situation experienced so far and the situation that would be desirable with the public policy if the available and/or mobilizable resources were used differently (Padioleau, 1982: 25). Only then can substantial change take place. The SRH policy under analysis is unlikely to have experienced such a process. It will be so difficult to implement that the social perceptions of the various stakeholders are so divergent.

Table 1 Trends in family planning performance

Indicators	2010	2017–2018
Percentage (%) of women aged 15–49 using a modern contraceptive method	11	14,6
Percentage (%) of women aged 15–49 in union who use a natural contraceptive method	4	6

Source: Data taken from République du Burundi/UNFPA (2022: 24)

Table 2 Views of healthcare staff on ASRH services (% agreement)

	Public	Private	Confessional	Nonprofit	In general
I advise teenagers to abstain from sex when they ask for contraceptives at the health center	81%	79%	76%	80%	79%
Teenagers should not have sex	55%	47%	65%	50%	55%
I agree with providing contraceptives to unmarried women	94%	79%	51%	50%	78%
The use of contraceptives goes against my faith and should not be offered to teenagers	28%	33%	60%	30%	37%
I feel comfortable talking to teenagers about contraceptives and sexual health	92%	98%	78%	100%	91%

Source: Data taken from République du Burundi/UNFPA (2022: 11)

A few elements of the SRH package may illustrate this:

(i) *Family planning: adherence is still low*: Despite the efforts made by the government and its partners over the last few years, family planning is still struggling to gain mass support. Table 1 gives an idea.

The percentage of women aged 15–49 using modern contraception has risen from 11% to 14.6% in 8 years, while the percentage of women aged 15 to 49 in union using a natural contraception method has risen from 4% to 6%. And while recent results are a step in the right direction, since "the acceptance rate for family planning methods rose from 20% to 23.6% between 2017 and 2021, against a target of 26%" (Republique du Burundi, 2022), Ministry of Health still has a long way to go.

Firstly, a natalistic culture reinforced by the actions of religious leaders: Christian churches represent 89% of the population and Islam 2.5% (ISTEEBU, 2008). Religious leaders wield immense hierocratic power over the faithful (Willaime, 2021), their teachings being inspired by the Holy Scriptures. Secondly, almost all healthcare professionals are in fact "anti-models" for the actions they are expected to promote: having many children themselves, they have difficulty convincing the public (Shwartz et al., 2022).

(ii) *SRH for young people and adolescents*: Not only do almost all healthcare professionals themselves have a strong religious culture but they are also all the more influenced by tradition because they have a considerable age gap with young people and adolescents.

According to Table 2 , 80% of healthcare professionals of all statuses advise young people to abstain from sex and refuse them contraceptives. As might be expected, faith-based healthcare professionals are the least tolerant of the sexuality of young people and adolescents (65% compared with an average of 55%) and are the least willing to provide contraceptives to unmarried women (50% compared with an average of 78%). And on the specific question of faith, they are the most severe, since when asked "*The use of contraceptives goes against my faith and should therefore not be offered to teenagers*," they score 60% against 28%, 33%, and 30% for professionals in the public, private, and nonprofit sectors, respectively.

(iii) *Highly controversial SRH education*: The Ministry of Education has introduced SRH education in secondary schools. However, many teachers are uncomfortable teaching this subject, given the taboo surrounding sexuality and the lack of specific training. As a result, many skim or skip certain points, such as lesson 12, "*the rights of young people and appropriate sexual and reproductive health (SRH) services*." This attitude is far from unique to Burundi and has been the subject of in-depth analysis in other African countries such as Nigeria (Otu, 2024). In Burundi, there was more or less fierce opposition in this respect: on the one hand, from many teachers and parents who feel that the subject would encourage their children to engage in early sexual activity. On the other hand, from religious denominations in general and the Catholic Church in particular, a letter from the Archdiocese of Gitega was sent to the Minister of National Education in October 2021 (collection of 40 signatories) requesting that lesson 12 "*be removed from the curriculum and replaced by another lesson that encourages young people to abstain, as Burundian culture advocates*" (ChristianAid & OAG, 2022: 28).

In short, SRH education has difficulty gaining full acceptance, firstly in schools, which are more inclined to focus on biology, secondly among parents, where tradition inhibits dialogue between parents and children, and thirdly among religious denominations who fear that SRH education will encourage schoolchildren to engage in debauchery. In all cases, the various stakeholders have a more or less deep-rooted religious culture, which nonetheless shapes their actions irrespective of their respective status (Gashema et al., 2019).

Contribution of Religions to the SRH Policy

Because of their broader scope than the health sector, religions undoubtedly contribute to the success of the SRH policy in so far as their teachings on sexuality implicitly target the same objectives such as the reduction of undesired pregnancies

among young people and adolescents, the fight against STIs, family planning, etc. Conversely, by discouraging modern contraceptive methods among young people and adolescents, many religions inevitably contribute to the relative failure of SRH policy.

Contribution of Religious Organizations to the Success of the SRH Policy

A closer look at the facts in Burundian society shows that religious organizations in all their diversity are making a substantial contribution to the success of the SRH policy in a more profound way than one might think. With their unquestionable hierocratic authority, religious leaders support the ministerial authorities in matters of SRH. Here are a few examples of what they are doing:

(i) *The socialization of the population of their faith from an early age*: Religions inculcate in their followers the more or less in-depth content of the Bible or the Quran in relation to sexuality. In fact, the common ground between the Christian and Islamic faiths is that fornication is a sin. There is a very clear demarcation line between what is permitted and therefore a matter for God and what is forbidden and therefore a matter for Satan. As a result, the more religious and practicing people are, the less likely they are to commit such a sin. Even in the case of a more or less accidental transgression, their inner conscience never ceases to accuse them; hence, the repentance practiced by different denominations mutatis mutandis. Given that 65% of Burundi's population is under the age of 21 (ISTEEBU et al., 2017), it is understandable that if the ban on fornication were strictly respected, there would be fewer births before marriage, at least for people who would like to get themselves married 1 day. In this way, natural contraception, which carries fewer risks in terms of the errors inherent in modern contraceptive technology and in terms of STIs or unplanned pregnancies, would be massively accepted by the faithful.

(ii) *Supervision of young people by schools*: Religious leaders supervise young people in their schools such as seminaries aimed at training priests, and primary and secondary schools run by Christian and Islamic clerics. With a scientific education that includes a good portion of religion, young people are more likely to continue their studies with less sexual activity and therefore to reach adulthood where sexuality is approached responsibly, particularly when they finish higher education. And with more solid education, we can assume that family planning would be easier (Gashema et al., 2019).

(iii) *Supporting the faithful through* "*community prayers*": Religions have several ways of ensuring the religious socialization. Let's consider at least two examples:

First, training children from an early age: The morning service for children known as "S*unday schools*" is well known to Protestant denominations. Little girls and boys learn the content of the Bible and end up forming a

"sibling group" to whom the notion of sin is inculcated from an early age. And when they are around 15 or 16, they join choirs. Their role is not only to sing well at mass but also to serve as role models for the rest of the faithful. They work under the watchful eye of a religious leader: in the event of sexual intimacy either between two choristers or between a chorister and another partner, the chorister in question is given a warning. If they fail to remedy the situation, they are expelled from the choir. Such a sanction is so shameful that very few choristers dare to face this sort of socioreligious "excommunication"! The same applies to other religions. In the Catholic Church, for example, the various stages that children go through, such as the sacraments of communion (aged 8–9) and confirmation (aged 11–14), eventually make them fully fledged Christians.

Second, coaching the faithful of all ages through "prayer cells" within the grassroots communities. For the Catholic Church, for example, "basic ecclesial communities" are organized on a weekly basis on a sub-hill in rural areas and on a street in urban centers. Here the faithful, both children and adults, meet to pray, moving from household to household as the place where they are welcomed. This becomes an opportunity to discuss all the community's issues, up to and including any sexual misbehavior by members. And if this is the case, the leaders offer advice in due course. In the event of insubordination, the case is brought to the attention of the parish and if necessary, the person is excluded from the prayer cell. Of course, the door to repentance remains open to the person penalized, religious leaders have repeatedly said, as long as the person concerned agrees to make amends, which also enables the religious organization to catch the "black sheep."

This is practiced in all religious denominations, including in Islam: there are "women's councils" where women of all ages meet and where experienced leaders prepare young girls for the life of a model wife in general and for the imperative need to remain a virgin for a good marriage in particular. Similarly, after prayers, the young men are given useful information about their future role as good fathers. In both cases, the mosque's management committee has immense powers to document cases of misconduct among the faithful. And in the event of indecency, severe moral sanctions can be decided against the recalcitrant. It should be noted in passing that, in addition to supervision, mutual assistance has developed between the members of the "prayer cell," to the extent that the latter assist any member in difficulty, for example, in the event of hospitalization, illness or death, etc. And this applies to all religious denominations.

In a nutshell, by socializing their followers from an early age on all the issues of daily life in general, and on the specific issue of sexuality within marriage in particular, and on the imperative of sexual abstinence for single people and especially young people and adolescents, religions go beyond a simple SRH policy. In fact, the expected results in terms of limiting births and protecting against STIs are likely to be greater than those that can be achieved through an SRH policy. The same

applies to the other components of the SRH policy as a whole, since even SGBV, unwanted pregnancies, etc., should be implicitly covered by God's commandments. And this is in this light that the contribution of religious denominations goes beyond simple SRH policy in terms of success, exceptions being inevitable, of course.

Contribution of Religions to the Relative Failure of the SRH Policy

According to available reports on the SRH policy in Burundi, it is clear that the policy is far from achieving its objectives. This can be illustrated by two indicators: the rate of acceptance of modern contraceptive methods and the number of undesired pregnancies in schools.

With regards to the first indicator, the efforts made by the Ministry of Health have certainly led to some progress, but the expected objectives have not been achieved. According to the report on the midterm evaluation of the *Maternal, Newborn, Child and Adolescent Reproductive Health Strategic Plan* (2022), "the acceptance rate for family planning methods rose from 20% to 23.6% between 2017 and 2021, against a target of 26%. This is also the case for the number of additional users of contraceptive methods. It was estimated at 173,692 new users in 2017, compared with 258,924 in 2021, against a target of 284,652" (République du Burundi, 2022).

As for the second indicator, the actions deployed by the Ministry of Health through the SRH for young people and adolescents program have produced only modest successes, as illustrated in Table 3.

Table 3 highlights that the 13–15 age group is the most vulnerable, in so far as the number of undesired pregnancies does not decrease over the years (from 62 in 2016–2017 to 90 in 2020–2021), while for the 16–19 age group, the reduction in the number of cases remains insignificant (339 in 2016–2017 to 256 in 2020–2021). Even for the age group made up of theoretically mature students, the trap does not escape since the reduction falls from 64 cases in 2016–2017 to 32 in 2020–2021, i.e., is reduced by only half. According to a survey conducted across the country, this is due to the fact that many young people and adolescents "*engage in several types of sexual relations that could expose them to poor health outcomes, including transactional sex, unprotected sex, sex with several partners and sex after drinking alcohol*" (Constenbader, 2021: 20).

To pinpoint the role of religious denominations in this underperformance of the SRH policy, it should be said that in reality, religions are the most powerful stakeholder

Table 3 Number of student pregnancies at the national level, by age group

Age category	2016–2017	2017–2018	2018–2019	2019–2020	2020–2021
13–15	62	78	40	46	90
16–19	339	366	272	229	256
20–23	64	86	40	40	32
Total	465	530	352	315	378

Source: Data taken from a report of Ministry of Health (République du Burundi, 2022: 37)

when their influence extends beyond the scope of the SRH package. This is why this influence contributes to the failure of the components of the SRH package:

(i) *Health professionals against some components of the SRH package*: In addition to health workers employed in faith-based structures who have already won over the cause of sexual abstinence, even their colleagues from other statuses are no less socialized in religious culture. For example, we saw in Table 2 that 81% of healthcare professionals working in the public sector (compared to 76% of faith-based healthcare professionals) specifically advise adolescents to abstain from sexual activities when they come to ask for contraceptives. Similarly, an average of 37% of healthcare professionals (compared to 60% of faith-based healthcare professionals) say that "the use of contraceptives goes against [their] faith and should therefore not be offered to teenagers." It is understandable that the deeply religious beliefs of most healthcare professionals, including those in the public sector who are normally paid to promote "SRH products," act against the wishes of their employer! Yet sexual activity among young people and adolescents is indeed a reality. As the abovementioned survey shows, recurring discussions between healthcare providers and teenagers show, in addition to unwanted pregnancies, that sexual activity is a reality despite the prohibitions inherent in religions and culture:

> First I [*the healthcare professional*] asked her [*the teenager*] to abstain, she replied that sometimes it's difficult for her to resist. If it's difficult, we offered her a condom because it will protect her against pregnancy and all STIs. She replied: 'But my darling doesn't like condoms'. You advise her to tell her boyfriend: 'You tell him that if you don't use a condom (…)', but the girl replies: 'No, madam, we've already talked about that'. As she was very insistent, I ended up giving her the method she was looking for. (Costenbader et al. 2022: 22).

(ii) *Rural "youth-friendly health centres" reluctant to promote SRH services*: While it is true that the main mission of "youth-friendly health centres" is to promote the *SRH of adolescents and young people* components of the SRH policy, religiously socialized community actors do everything they can to dissuade young people and adolescents inclined to use SRH services with a view to sexual activity protected against any undesired pregnancy or any STI. It should be noted that the inter-knowledge of the inhabitants around the health center and the Christian socialization mean that even the health professionals communicate discreetly with the teenagers' parents, which means that it is always preferable for young people to consult youth-friendly health centers as far away from their community as possible (ChristianAid & OAG, 2022).

(iii) *Openly anti-SRH actions by many religious leaders*: To illustrate the actions openly taken against the SHR policy by religious leaders, two comments made by two very influential priests in the Catholic Church are worth highlighting. Quoting the Beninese priest Théophile B. Akoha, the first priest firmly rejected any idea of the emancipation of young people in SRH: "*The watchword here is emancipation. There is in fact the illusory persuasion that an emancipated girl is*

one who knows how to manage her sexuality on her own, who is free of all cultural taboos and religious prohibitions. Chastity is no longer a value, but a waste. Young people have to do what they want and do it themselves. They no longer have any self-control" (Akoha, 2019: 64–65). Quoting the Beninese bishop Roger Houngbédji, the second forcefully asserts: "*The Catholic Church rejects contraception methods because sexuality is not a simple game, but must be part of a procreation project inspired by the Holy Scriptures. Single people should not give in to sexual impulses but abstain from them until marriage. That's why they don't need contraception!*". In this regard, a priest went further by quoting the pastoral of the Beninese bishop Houngbédji: "*From conception, from fertilization (meeting of sperm and the egg), the human person is already there. Touching the embryo is therefore eliminating a life, a unique genetic code*" (Houngbédji, 2022: 30). He therefore concluded by returning to this pastoral: "*in situations where civil laws come into direct conflict with the laws of God, the Christian must ensure that he only obeys God*" (Houngbédji, 2022: 21). Most Catholic priests subscribe to the views of Beninese priest Théophile AKOHA, who sees the SRH policy disseminated in several African countries as the result of insidious lobbying by the West to destroy Africa by distorting families and youth. According to Akoha, "the project of the new ethic is to insert itself into this beautiful harmonious whole [i.e. Africa] in order to destroy it" (Akoha, 2018, p. 31).

In a nutshell, religions systematically dissuade theirs followers from the SRH policy in several ways. By instilling the content of the Holy Scriptures, religious leaders do influence individual, social, and structural factors which come to shape a way of thinking about SRH and therefore a way of behavior within society (Nyebare-Baturaine & Omona, 2021: 24). It is from this perspective that we understand that whatever they are (health professionals, teachers, young people and adolescents themselves, etc.), all these people are first and foremost socialized into a religious culture opposed to the various components of the SRH policy. This is why, whatever their status, health structures (including youth-friendly health centers) converge to limit, by stealth if necessary, the scope of SRH services among unmarried people in general and young people and adolescents in particular. This is where religious denominations undoubtedly contribute to the failure of the SRH policy, at least at the level of the implementation of its "technical" components such as the promotion of sexual and reproductive rights among young people in school via sexuality education and out of school via youth-friendly health centers, and use of modern contraceptives to circumvent potential consequences of sexual activity (undesired pregnancies, STIs, etc.).

Conclusion

After examining the sexual and reproductive health policy implemented by the Ministry of Health in 2007 and its subprograms undertaken in 2016, on the one hand, and analyzing its complexity from conception to implementation, on the other, it is useful to draw a number of lessons:

(i) Burundi's SRH policy aims to respond to problematic situations observed throughout the health pyramid (top-bottom), such as the very high fertility rate, the lack of SRH education among schoolchildren, the existence of unwanted pregnancies in and out of school, STIs, gender-based violence, etc. However, as the social perceptions of the various stakeholders are not the same, solutions to the same problems inevitably diverge. For example, in the face of unwanted pregnancies, STIs, and uncontrolled births, religions advocate sexual abstinence while health ministry experts recommend the use of modern contraceptive methods.

(ii) The authorities of the Ministry of Health, although formally very powerful, have proved less decisive in the face of religious leaders with apparently diffuse power. In other words, the hierocratic power of the latter clearly outweighs the techno-scientific power of the former: religious denominations are deeply rooted in society and their preaching is perceived as inspired by the Holy Scriptures, hence their overwhelming legitimacy. Under these conditions, their recommendations are all the more likely to be observed in areas such as the sexual and reproductive health, where religion and Burundian tradition go hand in hand. The low level of acceptance of modern contraceptive methods is a good illustration of this. Paradoxically, religious preaching is not observed by the whole population either, hence the premarital sexual activity (cf. unwanted pregnancies in school and nonschool environments, STIs, etc.) observed throughout the country.

(iii) All in all, religions make a substantial contribution to SRH policy. By encouraging their unmarried followers to abstain from sexual intercourse and hence to control their sexual impulses, they contribute to the achievement of SRH policy objectives by reducing unwanted pregnancies, combating STIs, etc., with the corollary of delaying sexual activity, at least among well-practicing followers. In this way, they contribute to the success of the SRH policy. On the contrary, discouraging SRH policy components contributes to the failure to implement Burundi's SRH policy. This situation poses a highly ambiguous problem: with very real sexual activity among young people and adolescents, this means that many people, especially young people and adolescents, do not adhere to religious teachings and are paradoxically not adopting modern methods of contraception. This is why the government should initiate a dialogue with all stakeholders in general and religions in particular with a view to finding a solution that limits the unfortunate consequences of sexual intercourse: abstinence for the very devout believers and modern contraception for those who cannot abstain from sex.

Competing Interest Declaration The author(s) has no competing interests to declare that are relevant to the content of this manuscript.

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