



Article

Beyond 'Family Planning'—Local Realities on Contraception and Abortion in Ouagadougou, Burkina Faso

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Abstract: Family planning has long been promoted within international health efforts because of its potential benefits for controlling population growth, reducing poverty and maternal and child mortality, empowering women, and enhancing environmental sustainability. In Burkina Faso, the government and donor partners share a commitment to 'family planning', notably by increasing the low uptake of 'modern' contraceptive methods in the general population and reducing recourse to induced abortion, which remains legally restricted. This paper presents ethnographic findings that show the complexity of family planning within the social context of women's lives and care-seeking trajectories. It draws on participant observation in Ouagadougou, Burkina Faso's capital, and interviews with women with a wide range of reproductive experiences and providers of family planning services. First, the paper shows that women's use of contraceptive methods and abortion is embedded in the wider social dilemmas relating to marriage, sexuality, and gendered relationships. Second, it shows that women use contraceptives to meet a variety of needs other than those promoted in public health policies. Thus, while women's use of contraceptive methods is often equated with family planning within public health research and health policy discourse, the uses women make of them imbue them with other meanings related to social, spiritual, or aesthetic goals.

Keywords: women; family planning; abortion; contraception; Burkina Faso; ethnography

1. Introduction

Family planning has long been promoted as a part of international health efforts because of its potential to reduce population growth, poverty, and maternal and child mortality, as well as its potential to empower women and enhance environmental sustainability (Cleland et al. 2006; Starbird et al. 2016). It is commonly defined as the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births (Bongaarts et al. 2012). Family planning programs run by international and national agencies in donor-dependent countries typically focus on providing contraceptive drugs and devices to prevent pregnancy, as well as treatment of infertility but generally exclude abortion services, given the legal and social restrictions on abortion in many countries. It is widely assumed that if family planning programs are effective, fertility will drop and induced abortions will decrease, though family planning programs recognize that fertility is also influenced by women's status and educational level, and by child survival (Rutstein and Winter 2014).

With a population growing at about 3.1% per year (INSD et ICF International 2012), Burkina Faso, one of the world's poorest countries, has among the world's highest rates of population growth. According to the government of Burkina Faso, a voluntary increase in contraceptive prevalence of 1.5 percentage points per year would limit Burkina Faso's population to 39 million by 2050. On the other hand, a slower reduction of this indicator (0.5 percentage points per year) would increase the

country's population to 55 million by 2050 (Ministry of Health 2013). This second scenario would result in a high proportion of young people in the population and thus put undue pressure on available resources because the government would be obliged to allocate more resources to food, health, housing, education, and employment of the young component of the population, who consume goods and services but do not produce them (Ministry of Health 2013). It would therefore be a major challenge to reduce unemployment and poverty, as well as to provide access to education and health services. For this reason, family planning receives political attention as a strategy for social, economic, and health development, whereas abortion is restricted to cases of rape, incest, fetal malformation, or endangerment to the life of the mother. The legal restriction on abortion often lead women to resort to unsafe abortion at great risk to their health and life (Grimes et al. 2006). Moreover, given the restrictive abortion law, policy actors have appropriated the medicalized discourse on abortion diffused by global public health actors by portraying abortion as a consequence of women's 'unmet need' for contraceptive methods and emphasizes the need to 'create demand' for family planning (Storeng and Ouattara 2014). Reproductive governance in Burkina Faso is therefore much more oriented toward family planning.

Reproductive governance refers to the way national and international policy makers, civil society, and health care workers produce dominant reproductive goals and logics that are connected to the state official policies (Morgan and Roberts 2012). Reproductive governance is often enacted from above—delivered in the form of laws and policies and state programs (El Kotri and Singer 2019). In Burkina Faso, the reproductive governance is manifested through the way the government, international institutions, and Non-Governmental Organizations and local organizations share a political commitment to the aim of increasing the modern contraceptive¹ prevalence in the general population (KI 2017). Despite this political commitment to modern contraceptive use, it should be noted that women do not necessarily comply with official reproductive health policies and laws (Johnson-Hanks 2002; Guillaume 2006). Studies in Burkina Faso have shown that contraception is not used in many pre-marital sexual relations, resulting in a higher occurrence of unplanned pregnancies among young people, which leads to induced abortion (Rossier 2007). Thus, although abortion is legally restricted, termination of pregnancy outside legal frameworks is frequent (Baxerres et al. 2018), with an estimated rate of 25/1000 women in 2008² (Sedgh et al. 2011). The latest estimates suggest that 105,000 induced abortions occurred in Burkina Faso in 2012, the vast majority of which were clandestine procedures performed under unsafe conditions (Bankole et al. 2014). Abortion as a fertility management strategy in Burkina Faso is common thanks to attitudes towards induced abortion, which remains morally condemned in public but is often tolerated in private (Rossier 2007). In addition, women's attitudes towards abortion also reflect the diversity and availability of new, less invasive methods for inducing abortion, such as manual vacuum aspiration and misoprostol, which are relatively accessible to them (Drabo 2019). Furthermore, the supply of post-abortion care makes it possible for women to get care for 'incomplete abortion' (Storeng and Ouattara 2014). This reflects a gap between public policies and the daily practices of women, which can be visible through the way they manage their social and reproductive life. Studies on the use of reproductive technologies in Burkina Faso are dominated by demographic and medical discourses that reduce the use of contraceptives to their medical role and present abortion as resulting from a failure of contraception. This is not always the case.

In this paper, I examine the complexity of 'family planning', emphasizing local experiences and perspectives that complicate public health accounts of family planning as a straightforward and

¹ Public and private health care centers offer different types of contraception, including methods referred to as "modern contraceptives" such as hormonal implants or injectables, Intrauterine Devices (IUD), oral contraceptives, and condoms.

² Estimates for the same year show that the Southern Africa sub region has the lowest abortion rate of all African sub regions at 15 per 1000 women in 2008. East Africa has the highest rate, at 38, followed by Middle Africa at 36, West Africa at 28, and North Africa at 18 (Sedgh et al. 2012). The rate of Burkina Faso is therefore slightly below the average for the West African region (25 against 28). However, it should be noted that data on abortions are sometimes understated in countries facing an occurrence of clandestine abortions.

rationalistic approach to reducing fertility. Drawing on participant observation in Ouagadougou, Burkina Faso's capital, I discuss the cultural logics driving women's use of family planning.

As a wide body of anthropological literature has shown, women are not passive in the face of biomedical technology such as modern contraceptives. Rather, they make pragmatic choices, with responses ranging from acceptance to rejection or indifference (Lock et al. 1998; Paxson 2002; Manderson 2012). My starting point is that women's use of family planning services and methods must be understood within the context of women's life histories and the wider social dilemmas relating to marriage, sexuality, and gendered power relationships. Such an analysis cannot be restricted to women's use of contraceptives, but must also consider their resort to abortion as a means to manage their reproductive life. Following Manderson (2012) and Sanabria (2016) on the way contraceptives are appropriated by women for their personal needs, I also show how women use contraceptives such as injectables and implants to fulfil alternative needs to those promoted in public health policies, notably broader social and religious goals.

2. Context: Family Planning in Burkina Faso

Burkina Faso, which was a French colony until 1960, inherited a law from France that criminalized abortion, equated the use of contraception to abortion, and prohibited advertising of contraceptive methods. The institutional and policy environment of family planning evolved in the 1980s in order to meet the recommendations of various international conferences on population issues (Accra in 1971, Arusha and Mexico City in 1984, etc.). Therefore, the government introduced family planning policies in the early 1980s as part of a social, economic, and health development strategy (Tankoano 1990). This was made possible through the influence of lobbying from the Burkina Faso Association for Family Welfare (ABBEF), the local affiliate of the International Planned Parenthood Federation (IPPF), and the Midwifery Association of Burkina Faso (ASBF), with support of bilateral and multilateral donors, notably the United States Agency for International Development (USAID) (Tankoano 1990).

In 1994, the International Conference on Population and Development (ICPD) in Cairo reached a consensus on the promotion of the concept of "reproductive health and rights". The rights-based approach to family planning promoted at the ICPD emphasized freedom of choice, right to health, equitable service delivery, accountability, and empowerment, providing a safeguard against the coercive approaches that had been the cornerstone of population control efforts in the decades before (Hardee et al. 2014). The concept of reproductive health also allowed health advocates to demand action to save the lives of women from abortion complications where abortions remain legally restricted or inaccessible. Following the recommendation of the ICPD conference, post abortion care was introduced in Burkina Faso and many other African countries (Storeng and Ouattara 2014). In addition, the government revised the national policies and standards on family planning to include the right of individuals aged 18 and over to access family planning service.

In 2011, a regional conference on family planning in Ouagadougou resulted in a consensus called the "Ouagadougou partnership", which included nine francophone countries of West African Governments and their partners. The partnership advocates strengthening policy and legislative frameworks in its member countries, strengthening financial mechanisms and challenging socio-cultural barriers that limit women's reproductive health. This regional partnership responded favorably to the London Summit on Family Planning in 2012—organized by the Bill and Melinda Gates Foundation, the UK Government, and other developmental partners who launched the Family Planning 2020 (FP2020) initiative to revitalize the global family planning agenda (Ahmed et al. 2019). The goal of these partnerships is to accelerate the use of family planning services.

The widespread international and domestic commitment to increasing the uptake of family planning methods contributed to increasing the contraceptive prevalence rate (the percentage of women (15–49) who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used) in Burkina Faso from 25.4% in 2016 to 31.7% in 2017 (CIA World Factbook 2018). This prevalence is lower than in countries such as Ethiopia (40%) and

Kenya (60%), but remains one of the highest in the West African sub region ([CIA World Factbook 2018](#)) A partial explanation for the relative increase in contraceptive prevalence may be the improved availability of implants, which have a low discontinuation rate ([Ahmed et al. 2019](#)).

In January 2019, the government demonstrated its commitment to family planning by adopting a decree that instituted free family planning services. Other actions taken to boost the supply to family planning services were the promotion of community-based distribution of oral contraceptives and weekly monitoring of contraceptive products in order to avoid stock outs. It should be noted that the offer of family planning services targets women much more than men. Apart from the male condom, the 'modern' methods designed to be used by women are the most promoted in health care structures. Vasectomy, which is a method of male sterilization, is infrequently promoted and used. In addition, in public health facilities, family planning is provided in maternity or childcare services, which are spaces dominated by the presence of women ([Rossier and Hellen 2014](#)).

3. Methods

This paper draws on ethnographic doctoral research conducted between March 2016 and February 2017 in Ouagadougou, Burkina Faso. I conducted participant observation in streets and in the marketplace, interacting regularly with various women and drug vendors. I observed pubs and a main thoroughfare of Ouagadougou where many hotels, restaurants, and pubs are frequented by men and women. Among these men and women, there are street drug vendors and female waitresses or sex workers who are often referred to collectively as "les filles de nuit" (girls of the night).

Informal interactions in these places gave me the opportunity to start conversations around the issue of contraception and abortion and to negotiate in-depth interviews with some of the women. During cultural events in Ouagadougou, public authorities established a merchant space for traders. Drug vendors are among these traders, and I spent the days in the stall of one drug vendor who was selling 'traditional' contraceptive methods and other drugs purchased by women. I spent between three and six hours over two days, which gave both an opportunity to talk with both the drug vendor and some of his clients.

Alongside these observations and informal conversations, I conducted 46 in-depth interviews with women to explore their reproductive health histories, future intentions in term of reproduction, their perceptions and practices in relation to the use of contraceptives and abortion, their decision-making processes, gender, and social relationships. I recruited women from post-abortion care and family planning clinics (in three primary health care centers and two hospitals). I got in contact with those women through caregiver-intermediaries.

The other women were recruited from my social network (neighbors, former classmates, friends, etc.) during my interactions with them or upon request to participate in my study. For example, I met some of them by chance and they asked me questions about my life and my work. I took that opportunity to inform them about my research and told them that I wanted to interview any women (who had already had an abortion, used contraception, or who were not using contraception) who would agree to participate, including them if they wished to take part. Furthermore, to include other people I did not know, my surroundings connected me with other women: their friends, the friends of their friends, and their relatives, etc.

I conducted the interviews in the participants' living area or in places, they frequented regularly (street of Kwame Nkrumah or cafeteria).

All the women and health care providers I conducted interviews with were informed that research was taking place within the framework of my academic PhD research, and they consented orally to participate. I also reassured them they were not risking anything by sharing their abortion experience with me. Furthermore, by reflecting on my ethnographic relationship with women, I can say that my ethnicity could have lead women to open up more to me. Women implicitly equated me with one of them and therefore could easily express themselves without embarrassment and produce a critical discourse on modern contraceptives.

The women were between 18 and 42 years old. Ten of them were students, seven public servants, four employed in the private sector, five petty traders, eight housewives, eight “filles de nuit” or sex workers, three cleaners, and one maid. Twenty were married, six were co-habiting with a male partner, eighteen were single, one was divorced, and one widowed.

I also interviewed 14 health care providers in charge of family planning and post abortion care services from nine public health care facilities including one university hospital, one district hospital, three medical centers, and four primary health care centers.

I conducted the interviews in French (50 interviews) and the local languages Mooré (six interviews) and Dioula (three interviews), depending on my informants’ preferences. I speak all three languages fluently. I recorded the interviews with my informants’ consent, except for three participants who felt more comfortable with note taking. Interviews lasted between 20 and 90 min.

I analyzed the ethnographic data (interview transcripts and field notes) thematically, drawing on both deductive and inductive analytic approaches (Braun and Clarke 2006). I reviewed my field notes and transcripts using certain preconceived categories derived from previous studies (Teixeira et al. 2015; Adjamagbo and Koné 2013), such as women’s reproductive experience, affective trajectories, relationships with contraception and abortion and the decision-making processes in relation to these methods, and their choices and motivation of contraceptive methods. I also categorized and summarized themes that emerged directly from the data using inductive coding, such as the use of contraceptives at the margin of public health policies.

Information gathered from research material (interviews, field notes, and observation) allowed me to summarize the women’s stories, which I used to write “problematized portraits”, i.e., a portrait of a research participant around an issue they experienced and described based on a specific context (Adjamagbo and Koné 2013).

I obtained ethical approval for this study from the Ethical Committee of Burkina Faso. The Norwegian Centre for Research Data approved the study’s procedures for handling personal data. The names of participants cited in the quotes are pseudonyms. All the interviews were transcribed in French. I have translated quotes from French, More, and Dioula into English. The data are not publicly available due to privacy or ethical restrictions (Drabo 2017). Below, I set out the broader policy context for family planning policies in Burkina Faso before describing women’s lived experiences of ‘family planning’.

4. Local Understanding of Family Planning in Ouagadougou

Local understanding of family planning is illustrated through the way women and health workers define this notion and, secondly, through the way the interaction of health workers and women produces a unique definition of family planning that is close to their social world.

When asked to define ‘family planning’, women often reproduced information they had received from awareness campaigns in the media; from health workers and NGOs in health centers; and during social interactions with acquaintances, colleagues, or friends. They described family planning as a method that allows individuals to space and to limit births through the use of contraceptive methods. As Juliane, a single, 28-year-old woman, explained:

Family planning is a system to space births, but I think it is also used to limit the number of births. Family planning can be done through contraception, which for me is a method that allows the woman to control her reproductive cycle. Therefore, it is to avoid compromising situations where you get pregnant while you still have a child at a young age or at a time you do not want, that is to allow women to choose the ideal time for them to have a child. Contraceptive methods that exist are condoms, pills, injections, IUDs . . .

In Moore and Dioula (the two main spoken language in Burkina Faso) the closest terms to ‘family planning’ are designated by the expressions ‘rogm yaagre’ and ‘den bo gnogola’, respectively, which both mean “spacing birth”. This emphasis on birth spacing is an idea that health care providers often

express during counselling sessions. In addition to the idea of spacing birth, health care providers highlight family planning as providing economic benefits for couples and the ability to allow couples to experience sexuality without necessarily having children. As stated by a midwife working in a primary healthcare center:

Family planning is to allow the couple to enjoy their sexual intercourse without having unwanted children, allows the couple to plan, to space, to have healthy children [at] the number that suits them with a significant age gap, allows the family to enjoy their work and to benefit their income.

Another health care provider put forward the idea of “responsible procreation”:

When I hear family planning I see responsible procreation, I mean spacing of births and not limitation of births only as many people may think. Therefore, for me, family planning is all the methods that allows couples to enjoy fully their sexuality without being confronted by unwanted pregnancy.

Care providers thus emphasize different aspects of family planning, including ‘modern’ and ‘natural’ contraceptive methods, which are the only type promoted in some health care facilities belonging to Catholic groups that prohibit condoms, Intrauterine Devices (IUDs), injectables, pills, and implants. However, the notion of responsible procreation and prevention of unwanted pregnancies that healthcare workers highlighted was not mentioned by the majority of women I spoke with.

Women often reduced the notion of family planning to the so-called “modern” methods, but at the same time talked about a broader set of practices that prevented pregnancies. For example, when women say that they “do not do “family planning”, this does not mean that they do not take precautions to avoid pregnancy. By saying so, they referred to the non-use of modern contraceptives because, when I asked whether they do anything to avoid pregnancy, they mentioned interrupted coitus, periodic abstinence, the use of necklaces, and concoctions of plants (which some women called the “African pill”). According to thirty-seven-year old Sarata, for example, the “African pill” is “the roots of plant that you crush to have a potion that you purge yourself with after sexual intercourse”.

Moreover, women often designate modern contraceptives as “drugs of white people,” a designation that carries negative connotations and invokes the suspicions that they have about these categories of contraceptives, especially related to side effects. As Yvette, a thirty-eight-year-old single mother of two explained:

The drug of white people creates too many problems for women, it blocks the belly (causes sterility), some women become fat, others their menses come and it doesn’t stop. There are no side effects with our African pill. You are comfortable with it. The only thing you do is to purge yourself to kill spermatozoa and it’s over.

When it comes to abortion, however, both women and health workers define it as the fact of ending a pregnancy before its term and do not include it in their description of family planning methods. Women use the term “*enlever la grossesse*”, which means to “remove” the pregnancy in French or “*sam puga*” and “*kono tchin*” (to destroy the pregnancy) in Moore and Dioula, respectively, to describe induced abortion. They mention a variety of drugs and techniques that can be used to terminate a pregnancy: manual vacuum aspiration, misoprostol, a drug called “three days clean” or Chinese drug, potassium permanganate, and plant concoctions.

Women and healthcare providers often use wording that break with public discourses during the supply of family planning services. Modern contraceptives are renamed in non-technical terms by health care providers to describe contraceptive methods in ways that are meaningful to women. For example, for women who only understand the Moore language, caregivers use other expressions to familiarize clients to methods and present contraceptives. For example, caregivers describe IUDs as “what is inserted in the ‘*rogsa*’ (uterus),” while the term ‘pique’ is used to refer to injectable contraceptives and

'*n'ninguidi kan ni wa*' or 'what is put here' refers to implants. In addition, the caregiver gestures with his or her arm to indicate the place they insert the contraception.

By presenting the different methods according to their effects, they use the term "what works with blood" to evoke the hormonal nature of implants and injectables. The naming of contraceptives through other forms of expression shows how the social context manages to create a diverse formulation of scientific or technical notions, and illustrates a local way of understanding family planning.

In the next section, I explore how women's use of the different methods and their motivations to choose one method over another is embedded in their sexual and reproductive life and the relationship with their partner.

5. Women's Sexual and Reproductive Life Experiences and Practices

5.1. *Managing Reproductive Life: The Role of Contraception and Abortion*

Contraceptives and, to a lesser extent, abortion play important roles in women's sexual and reproductive life experiences. The study participants reported to use several methods to avoid pregnancy depending on their marital status, their parity, and their relationship with a partner. This is illustrated by the story of Rita, a woman I meet in a family planning care unit of a primary health care center.

Rita is a thirty-five-year old married woman who works as a cleaner. She has two daughters. Rita used no contraceptive methods before marriage. To avoid pregnancy before she was married, she avoided intercourse two or three weeks after her menstrual period. She would use menstrual tampons outside of her period in order to dissuade her partner because he refused to use condoms. After getting married and giving birth, she decided to use pills in order to delay pregnancy. After a few weeks, she changed the pills to an injectable, as she often forgot to take the pills. After some time, she stopped renewing the injection because she was not sexually active due to the absence of her partner. Later on, she engaged in another relationship and decided again to use implants in order to avoid a pregnancy before marriage. A few months later, under the pressure of her partner, Rita removed the implant, became pregnant, and delivered through caesarean section. After the birth, caregivers advised the couple to use a contraceptive method (injectable, implant, or IUD), but Rita declined. As she put it: "I don't want to take something in my body while I'm breastfeeding the child".

Rita's case highlights the complexity of the use of contraceptive methods. At different times, she displayed an attitude of avoidance, use, and change of methods in relation not only to different phases of her life: celibacy, union, separation, post-partum, and breastfeeding, but also because of the (hidden) advantages and disadvantages specific to each method.

While Rita had not experienced an abortion, other women used abortion and contraception alongside each other to manage their reproductive lives. For example, Salimata, a thirty-seven-year-old woman started using pills at the age of 18 to avoid pregnancy before marriage. During my interviews with her, she reported that a pregnancy before marriage would be unwelcome in her family because of their traditions and religious affiliation. As she said, "I come from a Muslim family and, besides, we have our tradition when you take a pregnancy automatically it is outside (meaning that you leave the house). Later on, for fear of illness and being overweight, she decided to stop taking contraception after four years of use. After this cessation, she experienced three pregnancies (within four years) before her marriage, each of which ended in induced abortion.

The case of Salimata is not unique, as other women I spoke to reported having undergone between one and three induced abortions. Sixteen women reported they had undergone induced abortions in the past. Together, these 16 women had 23 abortions between 2010 and 2017. Ten of them reported using misoprostol to terminate one or more pregnancies, while other methods included manual vacuum aspiration (10 women) potassium permanganate (one woman), Chinese pills (one woman), and recipes made from plants (one woman). Four had already experienced the used of manual vacuum aspiration and misoprostol together.

There are also women who declared they never used the so-called modern contraceptive methods because of their side effects (gaining weight, lack of menstruation), but instead resorted to abortion when they had a pregnancy that they did not want. They started using what they call “African pills” after discovering it contraceptives’ properties from friends. This is highlighted in the case of Annika, a woman who confessed to having had several abortions. She declared she used herbal decoction that she calls “African pill” to stop having unwanted pregnant.

5.2. Gender Relationships, Choices, and Decision-Making Process

Divergent interests regarding family size and the choice of contraceptive characterize gender relations. The women’s narratives emphasized men’s influence over women’s reproductive lives. They described men adopting both attitudes of reluctance and encouragement in the adoption of contraceptive methods. In some cases, men’s skepticism towards modern contraceptive methods encouraged women to use strategies of concealment, like Rita who decided to insert the implant in her thigh fearing that her partner could see it by feeling her arms if it was inserted there. In other cases, women chose to use injectables because they considered them more discreet, or they kept their health records in healthcare facilities with the support of health workers in order to hide their use of contraceptives. However, although men can be an obstacle to the use of contraception, in other cases women claimed to have been forced to use contraception by their male partner, such as Habiba, a twenty-two-year-old married mother of two:

Good! To be honest, it is something that comes from my husband because I wanted a third child. He stopped having sex with me unless I was using a modern contraceptive method. He said that because our financial situation is not too good, it is better to limit to two children. Well, I told myself since he is the head of the family; I have to follow what he has decided. I have been using Norplant since 2014.

Pressure from men who encourage their partners to use a modern contraceptive method is also illustrated by the experience of 35-year-old Zara, a married mother of two:

Actually, I was not using any contraception method since I mastered my menstrual cycle, but when I gave birth, my menses were not coming. My husband did not want to take any risk—he practically forced me to take a contraceptive because he said he does not want another child for the moment. I went to take the pills.

These examples illustrate that both women and men can be favorable or reluctant to use modern contraceptives. Therefore, a key issue in the choice of a contraceptive method is the weight given to the perspectives of each individual in a couple. At this level, there is inequality between men and women because women’s practices are adjusted in relation to the injunctions, advice, and motivation of their partner. The power relationships that speak in disfavor of women force some of them to use their agency or capacity to act in order to impose their will in the management of their reproductive life without creating conflict with their partners.

5.3. Sexual Practices, Dilemma and Abortion

The need to let the man feel pleasure during sexual intercourse leads women to use products to shrink their private parts and not use condoms. This situation exposes them to unwanted pregnancies that end with abortion. Single women looking for a romantic relationship that can lead to marriage often face several dilemmas. They want to avoid getting pregnant while capitalizing on sexual life. Due to the difficulty of reconciling sexual spontaneity with contraceptive planning, some single women see the use of other contraceptive methods as non-applicable to them as they already use condoms, which they deem not only less constraining and without side effects like pills, implants, and injectable contraceptives, but also because of its protective effect against sexually transmitted diseases. When they do not use condoms, emergency contraception is also a means they use to protect themselves against unplanned pregnancies.

For example, the *filles de nuits*, who are involved in sex work, often have romantic and sexual relationships that they hope will eventually end in marriage. Therefore, when they meet a man, they commonly use products to shrink or narrow their genitals in order to allow their sexual partner to feel friction during sex and to conclude that they are a ‘good girl’ because they do not have “thick genital organs” that allegedly characterize girls who are too much involved in sexual intercourse.

The products they use are drugs sold by street drug vendors, such as *la craie* (‘the chalk’ in French), a white rod-shaped product that women insert and remove from the vagina a few hours before intercourse. Women told me they used *la craie* to seduce their sexual partner to gain his trust and hope for a more stable relationship in a marriage.

According to some women, the best way to use it is to have sex without a condom in order to allow the sexual partner to feel the friction. Women face a dilemma: using *la craie* and having unprotected sex with the risk of getting pregnant or having protected sex with the condom while running the risk of losing the coveted future husband. In this dilemma, the choice of *la craie* is obvious for some of them. However, in the case of an unplanned pregnancy, they resort to abortion when the relationship with their partner does not evolve as they wish or when they have doubts about his sincerity. As illustrated by the words from Theresa, a twenty-eight-year-old single woman:

When I attend family events such as weddings, people don’t respect me because I have no husband”. I met a man who wanted to marry me. I always used *la craie* to shrink my vagina before having sex with him. If I do not use it, he is going to disturb me with many questions. With that, no one knows who I am or what I am doing. After, I became pregnant but the guy was not serious in the relationship and I decided to terminate the pregnancy without him knowing it.

Women’s attitudes and practices are not stable, as each woman has a specific way of dealing with the choice of method, including abortion, based on her social situation, her needs, and her expectations. The diversity and the characteristics of each method and the choices women make defies any attempt to create a hierarchy of the methods, as women use them according to logics that are not linear. Women’s attitudes are influenced by the role they play in the management of their reproductive and social lives. All methods allow women to make decisions based on their personal situation or the social, cultural, or religious context in which they live.

6. Beyond the Scope of Family Planning: Contraception at the Margin of Public Health Policies

Although the intended purpose of contraceptives such as implants and injectables is to prevent pregnancy, the participant women often used hormonal contraceptives to fulfil social or religious needs.

6.1. Contraception Use and the Fulfilling of Religious Rituals

To perform the fasting of the month of Ramadan, some Muslim women reported having contraception injected a few days before the beginning of the fast in order to stop menstruation. This is because, in the Muslim religion, it is forbidden for women to perform rituals like praying and fasting while menstruating. During Ramadan, once the fasting period is completed, the women can catch up on the days they missed during menstruation by fasting on their own before the start of the next Ramadan. There are women who find it difficult to have to fast alone after the “atmosphere” of Ramadan has passed. Therefore, the injectable allows them to participate fully in Ramadan, as Rahina, a married thirty-one-year-old Muslim woman, explained. She started using the pill after the birth of her first two children in order to space the next births. However, she stated that she did so reluctantly because she worried about possible side effects similar to those from other types of modern contraception. Despite this, she decided to have a Depo-Provera injection to stop her menstrual period in order to do the fasting of Ramadan without interruption as she said: “a friend told me that when she takes Depo-Provera she does not see her menses for three months. That is what motivated me to use it during

Ramadan. You know it is difficult to fast alone when Ramadan is over. When I took the injection it worked perfectly ... ”

Women resorting to an injectable contraceptive to stop menses is not limited to Ramadan. Other women I interviewed revealed other religious motivations for using contraceptives. For example, Rahina explained that her mother's co-wife, a thirty-year-old woman, took the injectable in order to stop her menstrual period before going for a pilgrimage to Mecca with the intention of performing the rituals without interruption, because menstruating women are not permitted to pray. These examples illustrate how women can use an injectable despite fear of side effects in order to perform religious rituals.

Although some women used contraceptives for such religious purposes, other Muslim women reported that the absence of menses could raise suspicions from their husbands, who are often opposed to the use of modern contraceptives. As thirty-nine-year-old mother of four, Fati, explained:

When I did injections, my menses disappeared. Because of that, I have to pray every day. Yet, a woman cannot pray every day unless she has an absence of menses due to pregnancy. This is not my case. Therefore, there are times I have to hide from my husband to pray because if he sees me praying every day he will ask me many questions.

This case illustrates the limited decision-making power a woman may feel over her reproductive life, and how she has to balance her religious motivations against keeping the peace within her marriage.

6.2. Contraception Use and the Shaping of the Body

Another example that women's use of contraceptives does not necessarily comply with public health policies was the claim of using contraceptive implants in order to alter bodily appearance. For example, Angel, a twenty-eight-year-old single woman, explained that she noticed that some of her friends had gained weight after using the implants, giving them a 'big ass', which allowed them to seduce more men than her. For this reason, she decided to use implants to increase the size of her buttocks, albeit unsuccessfully so:

I use condoms before any intercourse so I don't need contraception. The Norplant I tried to see something. My friends use it and some of them have a beautiful body. I want to be like them, that is why I used it in order to see if it suits me. I'll remove it because it does not work with me.

Angel used hormonal contraception to shape her body for aesthetic purposes rather than to control fertility. She confided that she was wearing an artificial buttock under her dress. When she removes this, she explained, men discover her "lie", and the implants were intended to solve this problem.

As these examples illustrate, women use contraceptives to meet a variety of needs other than those promoted in public health policies. This happens in a context where they demand these products, pretending they want to use them for birth control purposes. Thus, while women's use of contraceptive methods is often equated with 'family planning' within public health research and health policy discourse, the uses women make of them imbue them with other meanings related to spiritual or aesthetic goals.

The case examples above also show women's agency relating to contraception. They do not remain passive in the face of the power of health care workers and the medical indication of each product. Furthermore, women's agency allows them not only to try to shape their bodies, but also to "control" their bodies to prevent restricting the practice of certain religious rituals that they would like to accomplish. Using an injectable to prevent menstruation allows Muslim women to fast or to make their religious pilgrimage without interruption, in the same way that men do.

Furthermore, it should be noted that if some women use these products without declaring their intention to health care providers, others do so openly and sometimes benefit from the support of the latter. As stated by this midwife in charge of the family planning clinic in one of the medical centers I visited:

Some women are frank; they will come to you and say they want contraception but they prefer Jadelle³ because it makes them fat. There are times when women decide to take Norplant only to become fat. Others use it to stop the menses in order to go for pilgrimage. When they use injectables, they do not see the menses for three months.

A gynaecologist mentioned the demand for contraceptive products beyond family planning reasons and the advice they give when facing these demands: “Close to the starting of pilgrimage, the generalists call us all the time for advice. It’s been like that for the last four years. We tell them to give progestin and then it’s ok”.

These examples show that health care providers provide contraceptives not only for the control of fertility but because women are not supposed to be sexually active as requested by the rules of the pilgrimage. By providing contraceptives outside of the family planning framework, health care workers consider their act as assistance to the grievances formulated by women. Most of the time, some of these acts are not recorded in the care register. However, in cases where they decide to report it, they keep an official discourse in the register (example: ‘contraception use for birth spacing’).

7. Discussion and Conclusions

The political commitment to family planning in Burkina Faso has made it possible to provide women with a growing range of contraceptive methods. However, this study shows that women’s experiences with some of the promoted methods (modern contraceptives) are often complicated or challenged by their relationship with men, their social life, and other activities. Reproductive governance enacted from above is therefore challenged by women’s pragmatism. In their reproductive life experiences, women use different approaches to manage their reproductive lives, including either ‘modern’ and ‘African’ contraceptives, or abortion. They vary between these different approaches pragmatically based on their needs to prevent or to terminate a pregnancy, similarly to what previous research in Ouagadougou has shown (Rossier et al. 2013). This demonstrates that women are not passive in the face of biomedical technologies as they use them strategically in pursuit of their own goals (Lock et al. 1998). In addition, the local understanding of family planning showed that women often resort to other methods (described as natural or traditional in public health discourse) to prevent pregnancy (Rossier et al. 2014). Furthermore, women’s attitudes towards family planning is embedded in heterosexual relationships where women’s reproductive choices are influenced by their social status, their social relationships with their sexual partners, their family members, and other surroundings, as confirmed by Paxson (2002). However, women’s behavior shows that one should be careful in putting them under the same umbrella because their reproductive choices are made in contexts with competing claims and expectations that they face as mothers, wives, or daughters (Paxson 2002).

As I have illustrated, the ability to make decisions relating to procreation with contraceptive methods is also heavily influenced by gender relations and women’s marital status. In general, married women who already have children want to use contraceptive methods to space or stop their procreation, while single women may use them in order to delay parenting as they might still want to have children later (Amsellem-Mainguy 2009), given the fundamental role that motherhood occupies culturally (Bajos et al. 2013). Other research from Burkina Faso suggests that men often condemn the use of modern contraception because they want to control the sexuality of their female partner (Ouattara et al. 2009). To avoid confrontations with their spouses or partners, some women try to bypass their partner by using more discrete methods such as injections (Désalliers 2009).

³ Norplant and Jadelle are Long-term contraceptives (hormonal) for women implanted under the skin, which is used for 5 years. Norplant consisted of six capsules of levonorgestrel (hormonal medication) while Jadelle has a two-rod levonorgestrel system. Norplant was the first implant that women used. Since then, women keep calling any implant Norplant. Therefore, it is common that health care providers mention Norplant to women while giving them Jadelle.

My findings resonate with the literature on women's adoption of family planning methods in West Africa that shows both compliance and non-compliance with the goals of family planning programs. For example, the so called modern contraceptives are often used as a means for spacing, as an alternative to periodic abstinence (Russell et al. 2020), which shows compliance with some of the goals of family planning programs. In terms of non-compliance, the purpose for which women use contraceptive methods does not necessarily coincide with the objectives of family planning programs, which advocate the use of contraceptives to limit or to space births. For example, studies have shown how contraceptive practices allow the modeling and control of the body's capacities (Sanabria 2016), as women use contraceptives (pill, injectable, implants) to reduce premenstrual pain and headache, to stop the menstrual flow, or to gain weight (Boydell 2010; Teixeira et al. 2015). Similarly, I have shown how, in Ouagadougou, women use implants and injectable contraceptives to satisfy other needs (getting fat or to stop menstrual flow) outside of the reproductive realm (aesthetic or religious needs). A study conducted in Indonesia, which is predominantly Muslim, echoes this finding (Hull and Hull 2001). This "demedicalization" of contraceptives to satisfy aesthetic or religious needs could bias the interpretation of statistics on contraceptive prevalence. There is also a need to highlight that the reasons motivating some women to use modern contraceptives (weight gain, loss of menstrual period) are the same reasons that prevent other women from using them in other studies across the world (De Zordo 2012; Williamson et al. 2009).

Research has also shown that, instead of using contraceptive methods to space or to limit births, women use them for having many children. Bledsoe and colleagues documented how women in the Gambia use contraceptive pills and Depo-Provera to manage birth intervals and enhance their ability to bear large numbers of children, rather than using them to reduce fertility (Bledsoe et al. 1994, 1998). Similarly, Désalliers has shown that couples in Burkina Faso use contraceptives not only to space or to limit births, but also to have large families and healthy children (Désalliers 2009). All these variations in the choices and their motivation defy generalization because women's contraceptive decision-making is embedded in the social and cultural context in which they live as well as in their individual experience (Sundari Ravindran et al. 1997).

Women's sexual and reproductive health behavior must thus be understood within a context of complex, and often competing, pressures and influences (Hoggart and Phillips 2011). The study has shown how women's search for marriage and "love" relationships, and pressure from men, explained the way they resorted to contraception or abortion. This happens in a context where, in Ouagadougou, sexual debut for young women is not formerly tied to marriage because prenuptial sexuality is tending to become commonplace in urban settings (Rossier et al. 2013). Abortion in their reproductive trajectory emerges as a solution to inopportune pregnancies (Paxson 2002). However, despite the contribution of abortion to the avoidance of unwanted births, it is a risky alternative to contraception given its illegality and the health risks that it carries in Burkina Faso (Ouedraogo et al. 2020). Consequently, modern contraception remains the suitable strategy for fertility control in Burkina Faso. However, in order to take into account the complexity of women's concerns, family planning services should include woman-centered counselling, and the offer of contraceptive methods needs to take into account both health and the broader social conditions within which reproductive health decisions are situated.

Healthcare workers' responses to women's demands for contraceptives for indications other than fertility control suggests that their practices are not only determined by professional standards but also depend on social context and their sensitivity to the grievances of their patients. Their attitude is not fixed and refers to their personal relationships with women. Both women and health care provider's behaviors concerning contraceptives can contrast with the orientations and aspirations of public health policies, much like other ethnographic research that has highlighted gaps between health programs' goals and the behaviors of patients and health care professionals in West Africa (Jaffré and Suh 2016; Bledsoe et al. 1994).

The main contribution of this ethnography is that it has produced 'thick data' on the way women and health care providers interact with the notion of family planning. This ethnography made it

possible to describe the local understanding of family planning in Ouagadougou and the underlying and varied motivations of individuals in their recourse to or use of contraceptive methods and abortions. The gap between the discourses and practices of health care providers, and the use of contraceptive methods at the margin of biomedical standards that this ethnography has shown, stipulates that the quantitative data regularly presented on family planning run the risk of distortion if they are not contextualized. Women adopt methods of hormonal contraception for many other reasons than to postpone or prevent giving birth to children, and they do not only abandon the methods because they want to give birth. This study calls for more contextualized understanding of the use of contraception and induced abortions.

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