

**The social life of reproductive health commodities in Ouagadougou, Burkina Faso:  
an ethnographic study**



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## Table of contents

<b>Table of contents</b> .....	<b>2</b>
<b>List of figures</b> .....	<b>5</b>
<b>Acknowledgements</b> .....	<b>6</b>
<b>Acronyms</b> .....	<b>9</b>
<b>Abstract</b> .....	<b>11</b>
<b>List of publications</b> .....	<b>12</b>
<b>Chapter 1: Introduction</b> .....	<b>13</b>
Reproductive health commodities .....	13
Reproductive health in Burkina Faso.....	14
Theoretical perspectives.....	16
Research questions and main contribution.....	16
Outline of the thesis .....	17
<b>Chapter 2: Theoretical significance</b> .....	<b>18</b>
Introduction.....	18
The social life of things.....	18
Reproductive governance.....	19
Population control and reproductive health .....	20
Reproduction health policies plagued by population control practices .....	21
Metrics in reproductive governance and their limits .....	22
Coercive practices and reproductive health technologies .....	24
Agency and pragmatism.....	25
Domestication.....	28

Conclusion.....	29
<b>Chapter 3: Ethnographic background and reproductive governance in Burkina Faso</b> .....	<b>30</b>
Introducing Ouagadougou .....	30
Women’s position in Burkinabe society.....	32
Reproductive health governance in Burkina Faso.....	34
The influence of the ICPD in Burkina Faso .....	35
Reproductive health in the MDG era.....	36
Family planning services and commodities .....	38
Abortion commodities and post-abortion care.....	39
Conclusion.....	41
<b>Chapter 4: Methodology and Ethical Considerations .....</b>	<b>42</b>
Introduction.....	42
Conducting sensitive research and ethical issues .....	42
Participant observation .....	44
In-depth interviews.....	46
An ‘intimate ethnography’ and ethnographic capital.....	47
Informed consent.....	49
Confidentiality .....	50
Reflexivity: negotiating my identity as a researcher .....	51
Analytic approach .....	52
Conclusion.....	53
<b>Chapter 5: Results.....</b>	<b>54</b>
Overview of articles.....	54

Paper I: Beyond ‘Family Planning’—Local Realities on Contraception and Abortion in Ouagadougou, Burkina Faso. (2020) .....	54
Paper II- The Domestication of Misoprostol for Abortion in Burkina Faso: Interactions between Caregivers, Drug vendors, and Women (2022). .....	56
Paper III: A Pill in the Lifeworld of Women in Burkina Faso: Can Misoprostol Reframe the Meaning of Abortion? (2019) .....	56
<b>Chapter 6: Discussion .....</b>	<b>58</b>
The social life of reproductive health commodities.....	58
Discrepancies between public health discourses and women’s pragmatic uses of reproductive health commodities.....	60
Reproductive health commodities and their impact in women’s lives .....	62
<b>Chapter 7: Conclusion .....</b>	<b>65</b>
<b>References .....</b>	<b>67</b>
<b>Papers.....</b>	<b>78</b>

## List of figures

Figure 1: An International NGO's announcement about the supply of contraceptive method

Figure 2: Advertisement for “traditional contraceptive methods” in Ouagadougou

Figure 3: “African” pill used by women highlighted in paper I

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## Acronyms

ABBEF: Association Burkinabè du Bien Etre et de la Famille (Burkinabè Association for Welfare and Family)

CPR: Contraceptive Prevalence rate

DHS: Demographic and Health Survey

ICPD: International Conference on Population and Development

INSD: Institut National de la Statistique et de la Démographie (National Institute for Statistics and Demography)

IPPF: International Planned Parenthood Federation

IUD: Intra Uterine Device

JHPIEGO: Johns Hopkins Program for International Education in Gynaecology and Obstetrics

LARC: Long-Acting Reversible Contraception

MDG: Millennium Development Goals

MoH: Ministry of Health

MSI: Marie Stopes International

MVA: Manual Vacuum Aspiration

NGO: Non-Governmental Organization

NSD: Norwegian Social Science Data Service

PAC: Post Abortion Care

SDG: Sustainable Development Goal

STS: Science and Technology Study

SIAO: Salon International de l'Artisanat de Ouagadougou

TFR: Total Fertility Rate

UN: United Nation

UNDP: United Nation Development Program

UNFPA: United Nations Population Fund

UNICEF: United Nations International Children's Emergency Fund

USA: United States of America

USAID: United States Agency for International Development

WHO: World Health Organisation

## Abstract

In recent years, there has been a growing focus on essential reproductive health commodities, including drugs and supplies for safe motherhood, contraceptives to control fertility and drugs like misoprostol, which has been hailed as a revolution for maternal health globally because of its potential to reduce pregnancy-related mortality and morbidity and to provide relatively safe termination or pregnancy.

In contrast to public health approaches that frame such commodities as technological means to achieve demographic and maternal health outcomes, this thesis draws medical anthropology and science and technology studies to explore how reproductive health commodities acquire different meanings and purposes as they circulate in society.

The thesis is based on ethnographic fieldwork conducted in Burkina Faso, a low-income country in West Africa where contraceptives and misoprostol play important roles in efforts to address very high fertility and mortality resulting from unsafe abortion. The fieldwork included participant observation, in-depth interviews with women of reproductive age, healthcare workers and informal drug vendors, and review of documents about national and international reproductive health governance.

Across three published papers, the thesis analyses the ‘social life’ of contraceptives at the intersection of formal and informal systems of reproductive health care, showing that healthcare workers and street drug vendors engage in ‘pharmaceutical diversion’ in disseminating misoprostol and knowledge about it to networks of individuals outside of the drug’s formal, regulated circuits. Meanwhile, women ‘domesticate’ reproductive health commodities to create new uses for them whether using misoprostol as an emergency contraceptive or to induce abortion clandestinely, or using hormonal contraceptives to achieve social, romantic, or bodily aesthetic goals. Though reproductive health commodities help women exercise agency over reproduction, negotiating access to them also exposes women to violence and creates new forms of inequalities.

## List of publications

Paper I: Drabo, S. (2020). **Beyond ‘Family Planning’—Local Realities on Contraception and Abortion in Ouagadougou, Burkina Faso.** *Social Sciences*, 9 (11), 212.

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## Chapter 1: Introduction

### Reproductive health commodities

Based on ethnographic research, this thesis explores how women, healthcare workers, and drug vendors in Burkina Faso's capital Ouagadougou relate to, use, and ascribe social meaning to reproductive health commodities. Internationally, there has been a growing focus on essential reproductive health commodities as part of broader efforts to improve reproductive and maternal health, including drugs, supplies for safe motherhood and prevention and treatment of sexually transmitted diseases, contraceptives, and condoms. Recognising the range of existing reproductive health commodities that are used in Burkina Faso, the thesis focuses on commodities used to control fertility and terminate pregnancies, both inside and outside formal healthcare structures, exploring how women's uses of contraception and abortion are altered by the introduction of a new reproductive health commodity, misoprostol. Misoprostol is a uterotonic drug with medical indications that include the induction of labour, prevention and treatment of postpartum haemorrhage, and post-abortion care (Tang et al. 2013), but that is also widely used to induce and self-induce abortions. Misoprostol is considered a lifesaving drug that can reduce pregnancy-related morbidity and mortality, particularly in settings like Burkina Faso where access to abortion remains limited by law (Miller et al. 2005).

Public health policy and research often frame reproductive health commodities as technological means to achieve demographic and maternal health outcomes, and often narrowly focus on questions of demand and access. The World Health Organization (WHO) for example, directed attention to the importance of "reproductive health commodity security" to ensure the supply of and access to such commodities (WHO 2011). Consequently, abortion has come to be framed as a consequence of the "unmet need" for family planning commodities (Casterline and Sinding 2000), and health authorities emphasize the need to "create demand" for family planning by educating women (Storeng and Ouattara 2014). Meanwhile, there is limited regard for how commodities are used in specific social contexts, including outside of formal healthcare settings, and the meanings they acquire to those who use them (Guiella, Ouédraogo, and Rossier 2004, Bajos et al. 2013). Furthermore, 'family planning' commodities like hormonal contraceptives are often treated as separate from abortion drugs, even though family planning and abortion exist along a continuum within the context of women's lives.

In contrast, this thesis approaches the diverse uses of contraceptives and family planning commodities as a rich window into broader social structures (Guillaume, Rossier, and Reeve 2018, Kobiane 2000, Congo 2007). Following Ginsburg (1995), I consider the social relationships

surrounding reproductive health commodities, how they are reinterpreted locally, and how they open for unpredictable practices, privileging the perspectives and practices of actors involved in their use. Rather than relying simply on women's self-reported use of commodities, I pay attention to the interactions between women and the health workers, pharmacists, informal drug vendors who are often intermediaries in the formal or informal distribution of reproductive health commodities. Moreover, I situate current uses of reproductive health commodities within the broader international and national 'reproductive health governance' (Morgan and Roberts 2012), the ways in which state institutions, donor agencies and Non-Governmental Organizations (NGOs) have historically used legislative controls and moral injunctions to control reproductive practices and the use of reproductive health commodities. As a doctorate student concerned with women's reproductive experiences, I endorse feminist scholars' position of making reproductive health commodities available to women, while acknowledging the social, economic, and legal circumstances under which those commodities are accessed and used (Suh 2021b, Prieto-Gonzalez 2005, Berer 2020).

### Reproductive health in Burkina Faso

Burkina Faso, a low-income country in West Africa, is an appropriate ethnographic study site for my thesis. Burkina Faso's fertility rate is among the highest in Africa, at 4.51 in 2018, (CIA World Factbook 2020). It also has one of the world's highest levels of pregnancy-related death, with a maternal mortality ratio estimated at 320 maternal deaths per 100,000 live births in 2017 (UNICEF 2021). Reproductive health commodities have a central place in the country's family planning and maternal health policies.

The government, supported by international donors, has committed to family planning programs since the early 1980s and more recently, in response to the Family Planning 2020 Initiative established in 2012, vowed to promote the use of 'modern' contraception (Druetz et al. 2021). This happens in a context where the total fertility rate (TFR) was 4.51 in 2018 and stated to be among the highest in Africa (CIA World Factbook 2020). Several methods of contraception are available in public health facilities and through community-based distribution strategies free of charge. These strategies are supported by national and international organisations, who regularly organise campaigns to promote and distribute contraceptive methods. Yet, family planning services remain underutilized. According to the most recent demographic and health survey (DHS), the contraceptive prevalence rate (CPR) of married women is 24% for all methods combined and 22.5% for 'modern' contraceptive methods, such as implants (10.4%), injectables (7.3%) and the contraceptive pill (3%) (MoH 2017). Women aged 15-19 in relationships are those with the lowest CPR at 12.6%, against 27.7% for those in relationships aged 30-34 (MoH 2017).



Levels of contraceptive use are higher in urban areas than in rural areas, and among women with a higher level of education (MoH 2017). Married women who already have children report using contraceptive methods to space or stop their procreation, while unmarried women use them to delay pregnancy (Amsellem-Mainguy 2009), or else reject modern contraceptive methods or use them sporadically due to fears they can cause sterility (Ouedraogo 2015). Women also use a range of ‘traditional’ methods for averting unwanted births (Rossier, Senderowicz, and Soura 2014).

Terminating unwanted pregnancies is difficult and risky in Burkina Faso, because induced abortion is legal only in pregnancies resulting from incest or rape, in the case of foetal malformation, or when the woman’s health is in danger. Even in these circumstances, abortion is difficult to access. Data on induced abortion in Burkina Faso are uncertain because most procedures are clandestine. Yet the most recent estimate is that 105,000 abortions occurred in Burkina Faso in 2012, the vast majority of which were clandestine procedures performed under unsafe conditions (Bankole et al. 2014)<sup>1</sup>. While an estimated 43% of women who had an unsafe abortion experienced complications that required treatment, many of them did not receive the medical care they needed (Bankole et al. 2014). According to the Ministry of Health, 10% of maternal death are due to unsafe abortion (MoH 2011).

This thesis grows out of my previous research in Burkina Faso. My Bachelor’s thesis showed how maternal mortality is not just a reflection of lack of access to emergency obstetric or post abortion care, but also of complex social and economic factors (Drabo 2009). Subsequently, with colleagues, I identified unsafe abortion as an important contribution to women’s ill health and death long after the 42 day period that conventionally defines a pregnancy-related death (Storeng et al. 2012). My MPhil thesis, conducted within a broader interdisciplinary study on unsafe abortion and access to care in Burkina Faso funded by the Norwegian Research Council (Storeng and Ouattara 2014, Ouédraogo and Sundby 2014, Ouattara and Storeng 2014, Ilboudo, Somda, and Sundby 2014), showed that when seeking medical treatment, women confront a variety of obstacles, including social and financial hurdles, as well as challenges connected to post abortion care management (Drabo 2013). Along with other social scientific research (Suh 2021b, Baxerres et al. 2018a, Moland et al. 2018, MacDonald 2020), identified how the concept, experience and

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<sup>1</sup> The World Health Organization classifies an abortion as safe if it undertaken using a safe method by an appropriately trained provider (i.e., per gynaecologist, nurse, or midwife) (WHO 2012). Less-safe abortions include those done by a trained provider but using an outdated method (e.g., dilation and curettage.), as well as self-induced abortions using a relatively safe method (e.g., misoprostol); least-safe abortions are those done by an untrained person (a provider or the woman herself) using a dangerous method (e.g., ingestion of caustic substances or insertion of a sharp object). The less and least safe abortion together is considered unsafe (WHO 2012).

safety of abortion is undergoing a profound shift with the entry of misoprostol, and in ways that demand further in-depth research.

### Theoretical perspectives

This thesis draws on social science and public health literature on abortion from the perspective of women, men, health workers, and the state. Drawing on theories from the fields of medical anthropology and science and technology studies (STS), I am interested in how reproductive health commodities acquire different meanings and purposes as they circulate in society. I pay particular attention to how these are used in the domestic sphere of women's homes, within healthcare delivery and in informal pharmaceutical markets, and within the policies and governance mechanisms of the state, NGOs, international organisations, and donor agencies. In Chapter 2, I describe how theoretical perspectives on the social lives of things (Appadurai 1988) inspired my approach, and examine how the concept of reproductive health governance (Morgan and Roberts 2012) helps to draw attention to the political nature of reproductive health commodities and the coercive practices that have often accompanied their use. Finally, I show how attention to the way in which reproductive health commodities have been used to exert control over women's bodies must be balanced with attention to women's agency and pragmatism (Lock, Kaufert, and Harwood 1998).

### Research questions and main contribution

The aim of this thesis is to provide original, ethnographic insights into how women, health workers, and drug vendors in Ouagadougou, Burkina Faso, use and experience reproductive health commodities. The specific research questions are:

- 1) Under what circumstances are contraceptives and misoprostol sold, circulated, and consumed?
- 2) How do women use contraceptives and misoprostol to manage their social, sexual, and reproductive lives?

My research contributes to social scientific literature on the meaning and practice of family planning and abortion by providing in-depth empirical evidence from Burkina Faso into how women's use reproductive health commodities in ways that public health scholars, practitioners or reproductive rights activists have not foreseen. I show that the use of reproductive health commodities is not restricted to the regulation of fertility in the manner indicated by public policy. Instead, their use enables individuals to comprehend, perceive, and explain reproductive health concepts (family planning, abortion, and sexuality) in a variety of ways and to subvert social, cultural, and legal form of control over reproduction and gender relationships. I show how,

beyond family planning and abortion, such commodities are used to attain commercial, aesthetic, and romantic objectives, as well as to carry out religious activities. They are essential technologies for many people, but their availability and access are unequally distributed, which has a severe impact on women's social and reproductive lives, with some women unable to obtain them due to their age or social or economic marginalization. I argue that reproductive health commodities are on the one hand, emancipating in allowing women to take charge of their reproductive health, but, on the other, introduce new forms of exploitation and reinforce social inequalities. The findings of this thesis challenges public health and demographic discourses that focus on standardized data to implement and measure reproductive programs and policies.

### Outline of the thesis

This is an article-based thesis that consists of three published works and a synopsis divided into six chapters. In this first chapter, I have introduced and defined the object of study and set out the research questions. Chapter 2 discusses the theoretical significance of the thesis, outlining how theoretical perspectives on the social lives of things, and the concepts of reproductive governance, agency, pragmatism, and domestication inform my analysis. Chapter 3 presents background information on the national and local context of Burkina Faso and my field site and describes how reproductive governance in Burkina Faso reflects the influence of international policy trends and institutions. Chapter 4 describes, and reflects on, the methodology and the ethical considerations. It defines my ethnographic approach, the choice of specific methods, and the strategies adopted to collect data while considering ethical considerations. Chapter 5 summarises the main findings of the two published articles and the book chapter that form the core of this article-based thesis. Chapter 6 discussing their unifying themes within the context of the existing literature and my research questions. The final chapter presents the conclusion and discusses the implications of the findings.

## Chapter 2: Theoretical significance

### Introduction

This chapter introduces the theoretical significance of the thesis, which draws on theoretical perspectives from the fields of medical anthropology and science and technology studies (STS). First, I describe the theory of ‘the social life of things’ that provides the overarching theoretical perspective of the thesis. Then, I discuss how the concept of reproductive governance, with its attention to how different historical configurations of actors use various forms of legal and social controls to monitor and control reproductive behaviors and practices, helps us to understand the social lives of reproductive health commodities. Finally, I show the need to analyze women’s agency and pragmatism in response to reproductive governance, including the way in which the theory of “domestication” directs attention to their uses of reproductive health commodities beyond their intended purposes. The chapter also reviews empirical literature from medical anthropology and the social sciences that apply these theoretical perspectives to elucidate the lived experience of reproductive health, and the diverse uses of reproductive health commodities.

### The social life of things

Theoretically, my starting point is that reproductive health commodities are not simply objects or things that people and policymakers apply to achieve pre-specified fertility and health outcomes. Arjun Appadurai’s edited volume *The social life of things* inspires this thesis because it examines how people sell and exchange ‘things’ in various social and cultural environments (Appadurai 1988). By focusing on culturally defined aspects of exchange and the processes of their social regulation, the essays in this book demonstrate how people value *things*, which in turn give value to *social relationships*. The interest in the social life of a thing allows the analyst to ask questions about things similar to the questions we ask about people: their origins, functions, social trajectory, or experiences, etc. (Kopytoff 1986).

Appadurai's (1988) concept of ‘social life’ has been applied to consider pharmaceutical medicine as a social and cultural phenomenon that can have a social life in the sense that they can have different meanings, applications, and uses depending on the space, the context, and the reasons for why they are used (Whyte, Van der Geest, and Hardon 2002). Cohen and colleagues (2001) argue that medicines have complex life cycles, with diverse actors, social systems, and institutions determining who uses what medications, how, when, and why. According to Whyte and colleagues (2002), the term ‘social life’ is a useful analytic tool to trace the path of material things as they move through different settings and are attributed value as singularities, gifts, or commodities. Applying this theoretical perspective to the study of medicines allows for studying them through

the social contexts in which various actors (policymakers, prescribers, sellers, and users), with often different perceptions, engage with them (Desclaux and Egrot 2015).

Medical anthropologists Desclaux and Egrot (2015) emphasise that using this theoretical perspective to study pharmaceuticals or drugs does not oblige a researcher to inspect *all* phases of a drug's life; instead, the researcher can study only one stage of its life. From that perspective, several anthropologists have applied this analytic tool to explore how people go beyond the product's medical dimension, as they are frequently redefined and interpreted by the people who use them (Hardon and Sanabria 2017, Cohen et al. 2001, Whyte, Van der Geest, and Hardon 2002, Childerhose and MacDonald 2013, MacDonald 2020). In other words, the meaning pharmaceutical products takes can depend on the way people perceive and use them beyond their initial function (Conrad and Barker 2010). Baxerres and Le Hesran (2011), for example, examine how local and global market practices and knowledge about medications in Cotonou, Benin, give rise to popular understandings of medicines, leading to forms of consumption and use that are not intended by manufacturers or prescribers. Meanwhile, Whyte and colleagues (2002) describe in their book *the social life medicine* how women in the Netherlands control conception and menopause by using medicines prescribed for mental distress. They also examine how street drug vendors in Cameroun's free market illegally sell drugs that are supposed to be dispensed by a trained health worker in authorised facilities. While in the Philippines, they documented how mothers buy pharmaceuticals for their coughing children to prove to neighbours and relatives that they are good mothers (Whyte, Van der Geest, and Hardon 2002).

Of direct relevance to this thesis, authors have also analysed reproductive health commodities through this theoretical angle. In *The Social Life of Pills*, Boydell (2010) looks at how the use of modern contraceptives contributes to highlighting the cultural meanings and practices associated with them. She demonstrates how the use of the contraceptive pill goes beyond medical considerations as the pill allows women to manage their social and sexual life. De Zordo (2016) study of the use of misoprostol in Brazil highlights the double life of the drug by showing how it is used legally and illegally for several obstetric procedures and abortions. MacDonald (2020) similarly describes how the concern with misoprostol properties to induce abortion made it a marginal drug in Senegal, a “pharmaceutical outlaw”, raising a question of who can deliver the medicine or not.

### Reproductive governance

To understand the social lives of reproductive health commodities, it is essential to situate their use, both theoretically and empirically, within the broader domain of the contested politics of

reproductive health. Although I focus on downstream issues in this thesis, the rising emphasis on commodities to manage reproduction can be understood in relation to the notion of reproductive governance defined earlier in chapter 1. With reproductive governance, reproduction, which appears to be an intimate and apolitical domain, integrates the politics of nation-states and the economy (Gibson-Graham 1996). Reflecting this perspective, feminist academics have suggested that contemporary policies on family planning must be contextualized within a larger history of (neo)colonial measures to restrict African reproduction (Kuumba 1999). These policies often evolve from issues of population control and reproductive health.

### Population control and reproductive health

Population control and reproductive health are two important paradigms of global reproductive governance that have existed since the 1950s (Brunson and Suh 2020). The *population control paradigm* understood high fertility in the global South as an impediment to economic development, political stability, and environmental sustainability. It is often associated with top-down, coercive interventions aimed at lowering birth rates, and even eugenicist and neo-Malthusian ideologies concerned with controlling the world's population (Bhatia et al. 2020). Although the eugenics movement was discredited at the conclusion of World War II because of its links to Nazism (Ziegler 2007), it influenced the population control paradigm that was popular between 1945 and 1990 (Lock and Nguyen 2018).

The United States Agency for International Development (USAID) supported NGOs in implementing family planning programs in newly decolonized nations with low-cost contraception, and introduced more economic justifications for population control (Suh 2021b).

In contrast to the population control paradigm, the *reproductive health paradigm* considers high fertility as a consequence of social and economic marginalization (Brunson and Suh 2020). Consolidated at the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994, this paradigm is anti-coercive, considers reproductive health as a human rights problem, and seeks to empower women in their reproductive choices (Lane 1994). Following the Cairo conference, various NGOs contributed to the establishment of family planning programs in several countries, with the purpose of assisting people in exercising their reproductive rights.

Human rights-based institutions and social movements helped reorganize reproductive governance in many countries by bringing change into national and local law on abortion, family planning, and gendered-based violence (El Kotni and Singer 2019). For example, feminist

organizations in Mexico have used human rights as an argument to facilitate abortion at home in a context of heavy abortion criminalization (Singer 2019). Storeng et al. (2019) described how donor-funded international NGOs work with local intermediaries to implement policy in line with global norms on reproductive health and rights to influence the restrictive policy environments for safe abortion and family planning in South Sudan and Malawi.

Like in the population control paradigm, reproductive technologies play an important role in the development of reproductive health policies. There are several reproductive technologies that are emphasized in the execution of global health programs, including the usage of contraceptives and misoprostol. Global discourses emphasize the contribution of these reproductive health technologies in enhancing the health of people and the quality of their social lives in general. In both popular media and public health literature, misoprostol has been described as a “revolution” in reproductive health care because of its potential to reduce mortality and morbidity related to unsafe abortion and post-partum haemorrhage in countries with restrictive abortion laws or with under-resourced health systems (Henderson, El-Refaey, and Potts 2012). Furthermore, global campaigns for family planning and Safe Motherhood also promote women as subjects who can improve their own and their families' health and well-being by judiciously using health services and resources (Bhatia et al. 2020). Family planning campaigns in particular have traditionally targeted Sub-Saharan Africa because they portray it as a place where overpopulation leads to climate change, religion fundamentalism and transnational migration to the global North (Hendrixson and Hartmann 2019). To reduce the effect of overpopulation and with over a billion dollars of funding from the Bill and Melinda Gates Foundation, the Family Planning 2020 Initiative pledged in 2012 to place 120 million women on contraception in 69 of the world's poorest countries by 2020 (Bendix et al. 2020). Donors, pharmaceutical companies, and NGOs rely on technical solutions by promoting for example long-acting reversible contraceptives (LARCs) such as injectables and implants (Bendix et al. 2020).

### Reproduction health policies plagued by population control practices

By critically looking at family programs and the emphasis on technologies, feminist scholars have analysed how contraceptive technology distribution is intertwined with the global neoliberal economy. Additionally, development programs and policies often portray modern contraception as a component of interventions that aim to release women from the burden of patriarchy and empower them (Mohanty 1988, Bhatia et al. 2020, Kuumba 1999). The global political actor often argue that population reduction is the main goal of these programs when conducted among the poor, wherever they live (Lock and Nguyen 2018). The political history of reproductive health technologies has led many scholars to cast a critical eye over how they are promoted and

distributed because the same methods were in vogue in past population control programs (Hartmann 1995, Kuumba 1999, Bhatia et al. 2020, Suh 2021a). The USAID, which supports numerous programs relating to reproductive health and maternal health, not only supported the earliest articulations of population policies, but continues to play an important role in supplying and funding reproductive health initiatives, such as the distribution of contraceptives, post abortion care and misoprostol (Foley 2007, Robinson 2011, Suh 2021a). Suh (2021a) describes how manual vacuum aspiration (MVA), which was the preferred abortive technique for low-resource settings during the time of population control, is still among the technologies suggested for post abortion care in reproductive health programs supported by human right discourses.

The resurgence or maintenance of reproductive health technologies that served population control policies leads feminist scholars to support the idea that the spectre of population control politics still influences current reproductive health policies. Bhatia et al. (2020), invoke the notion of “populationism” to describe this situation, referring to “populationism” as the plethora of approaches to analysing and solving social and environmental issues that are akin to Malthusianism, and which promote, perpetuate, and naturalize disparities along lines of race, class, gender, and geographic location. Furthermore, with measurable aims and detailed targets, the Family Planning 2020 Initiative depicts a kind of population control that is veiled by discourses centred on human rights or women's empowerment (Bhatia et al. 2020).

This notion resonates with the concept of the demographic dividend, which refers to an economic growth that results from a proportionate rise in the employed working-age population in comparison to the dependents (Groth, May, and Turbat 2019). The demographic dividend has long been seen as a critical component in economic growth, providing justification for measures aimed at achieving a more balanced age structure via birth control and family planning (Kotschy, Urtaza, and Sunde 2020). In recent years, concerns over how to capture a demographic dividend have come to dominate Sub-Saharan Africa's international development debate (Groth, May, and Turbat 2019). The supply of contraceptives methods to sexually active individuals is part of strategies that aim at capturing the demographic dividend.

### **Metrics in reproductive governance and their limits**

The social scientific literature on reproductive health emphasises the central role that metrics play in reproductive governance. Metrics are used in problem description, assessment, evaluation of actions and to set global targets for fertility reduction and health improvement. The achievement of national and global health and development goals may serve as a potent indicator of good (or bad) governance via the use of metrics. The ability to show metrics increasing or decreasing can



enhance political careers, renew contracts with donors, and demonstrate the competence and moral authority of health officials, who receive technical guidance and financial support to assist improving “bad” performance (Brunson and Suh 2020). Reproductive and maternal health advocates urge governments and donors to invest in women's health not only as a matter of human rights, but because “it pays” off when calculating both the health and economic value of the proposed interventions they support (Storeng and Béhague 2014). For example, the United Nations’ (UN) Sustainable Development Goals (SDGs) comprise a set of goals, targets and indicators that UN member states use to frame their agendas and policies from 2015 until 2030 (Hák, Janoušková, and Moldan 2016). The SDGs 3.7 and 5.6 support “universal access to sexual and reproductive health-care services, including for family planning” and “universal access to sexual and reproductive health and reproductive rights,” respectively (Starbird, Norton, and Marcus 2016).

Despite their potential to engage in the implementation and development of health policies, metrics have limits that several maternal and reproductive health scholars have highlighted. Thus, measures can have unexpected effects on service quality and availability, because the focus on counting and monitoring can divert attention away from other policies or interventions that try to reduce social and economic inequalities in the everyday life of pregnant women and health workers (Brunson and Suh 2020). The health records that serve as a support for the counting of health data do not necessarily reflect health problems and their policy implication. Suh (2019), shows how in Senegal the classification of induced abortion as miscarriage in post-abortion care records obscures the epidemiological scope of induced abortion and the needs and experiences of women who seek to delay or limit motherhood. In addition, an abortion legislation reform effort linked to a decrease in maternal mortality may be stifled by selective abortion categorization practices where healthcare workers underreport or conceal abortion cases they deal with in care settings (Suh 2019, Storeng and Ouattara 2014).

Donors’ demands for quantitative indicators of maternal mortality or family planning can compel local and national health system players to place a greater emphasis on the compilation of data than on the quality of treatment provided to women. For example, in her ethnographic research on maternal mortality in Malawi, Wendland (2016) shows how technological obstacles in data production skew and overlook local realities of delivery (how and where women give birth, quality of care delivery) and maternal death, and how politicians mobilise statistics as claims of success for politicians. Meanwhile, Suh (2021a) demonstrates how post-abortion data portray the intervention as a kind of rights-based harm reduction, despite the reality that the intervention consistently reinforces mistreatment and violence against women owing to the

stigma of abortion and its effects. She describes how, in Senegal, women accused of causing an abortion may be questioned by health staff, refused medication or painkillers, and even denounced to judicial authorities. Furthermore, she outlines how health professionals work to guarantee the validity of post abortion care (PAC) by officially reporting most patients as having had a miscarriage rather than an attempted abortion. These recording efforts obscure not only the real experiences of PAC recipients, but also the prevalence of abortion (Suh 2021a). For some scholars, demographic statistics such as the ‘unmet need for contraceptives’ is a reductionist discourse that does not reflect the lived experience of people and their relationship to family planning programs (Murphy 2012). For example, Ellen Foley (2007) highlights in her ethnography in Senegal that the number of women who are aware of family planning does not always correlate with the usage of contraceptives. She demonstrates how figures on the unmet demand for contraception are overestimated since most married women follow a logic of having children, which make contraception unnecessary for them.

### Coercive practices and reproductive health technologies

The social scientific literature on reproductive health often emphasizes that the use of reproductive health commodities and technologies often involves coercive practices enacted by healthcare workers. For example, a report revealed that around 148 women were sterilized involuntarily in California between 2006 and 2010 (Lock and Nguyen 2018). A qualitative study conducted in the United States found that women often described healthcare workers as a trusted source of contraceptive information but at the same time reported that some of the healthcare workers did not respect women’s preferences regarding contraceptive selection or removal, and often recommended intrauterine devices and implants disproportionately to socially marginalised women (Higgins, Kramer, and Ryder 2016). A household survey in Burkina Faso, Ghana, Malawi and Uganda demonstrated that health workers are often less responsive to the needs of young people and unmarried people when it comes to contraceptive methods (Amuyunzu-Nyamongo et al. 2005). A global systematic review shows that many healthcare workers wrongly believe that intrauterine contraception has serious side effects (pelvic inflammatory disease, infertility, uterine perforation, and extra-uterine pregnancy) and have a low willingness to provide it to eligible people such as HIV-positive women, teenagers, and women who do not have children (Daniele et al. 2017).

The relationships between users of family planning services and healthcare workers are characterized by asymmetrical power dynamics, where the dominant perspective is often that of healthcare workers (Russell, Sobó, and Thompson 2000). Research conducted by Senderowicz (2019) in an unnamed sub-Saharan country documented that there are a variety of coercive

practices related to the supply of contraceptive technologies, including biased counselling, severely limited method mix, outright refusal to remove implants, inserting a contraceptive device without women's knowledge or consent.

Numerical target-driven contraceptive programs may incentivise coercive behaviours as development agencies increasingly invest in family planning based on that (Bendix et al. 2020). Although reproduction is an area that concerns both men and women, analytical frameworks and political orientations toward fertility and family planning have focused more on women. Furthermore, coercion is also perceptible through gender relations and decision-making processes related to the use of contraceptives. In *Contraception Across Culture*, Russel and colleagues (2000) discuss how the development of new contraceptive technologies had profound implications for the social relationship between men and women. Through examples in Mexico and Bangladesh, they illustrate how women's low decision-making power forces them to use contraception without the knowledge of their male partners. To better hide from their partner and to avoid being subjected to violence, they use discreet methods such as injectables or Intra Uterine Device (IUDs) (Russell, Sobó, and Thompson 2000). In their study in nine sub-Saharan African countries, Mejía-Guevara and colleagues (2020) investigated the extent to which reproductive behaviour can be shaped by social relations and contextual factors focusing on gender norms. Based on DHS data on attitudes towards premarital sex and interviews conducted with women of reproductive age (aged 15-49) on family planning and fertility practices, they found that collective attitudes of acceptance toward domestic violence faced by women were negatively associated with contraceptive use and demand (Mejía-Guevara et al. 2020).

### Agency and pragmatism

While theories of reproductive health governance emphasize the use of several mechanisms and strategies (legislative, economic, moral, injunctions, coercion) to influence or control reproductive behaviours and practices (Morgan and Roberts 2012), scholars of reproductive health also alert us to the dangers of considering women as passive recipients of such mechanisms. In their book *Pragmatic Women and Body Politics*, Lock and Kaufert (1998) highlight how women resist reproductive technologies or choose to use them due to personal benefits.

Such pragmatism can be considered an expression of women's agency, defined as the capacity (in persons and things) through which something is created or done (Arnold and Clarke 2014). Giddens (1993), relates the capacity to make appropriate choices of action to a particular culturally defined context. Based on the notion of agency, Carter (1995) explains behaviours

related to fertility with two forms of agency: a passive form where individuals adhere to social and cultural conventions or rules, and an active concept where people deliberately choose their fertility level according to some form of rationality. From this perspective, using contraceptives is proof of *active* agency, while wanting a large family is a type of passive decision. However, such binary understandings of agency are rejected by scholars who show that women sometimes use contraceptive methods even when wanting a large family, and even, paradoxically, to maintain or increase their fertility.

Jansen (2020) ethnography of students' perspectives on fertility control and induced abortion in Madagascar highlights a range of issues that determine their choice of methods. She highlights that female students' reluctance to use modern contraceptive methods depend on their parents, their male partner, and their own worries concerning potential side effects (e.g., loss of menstruation) that could compromise their fertility. For this reason, some of them avoid contraceptives and instead employ periodic abstinence or the calendar method for fertility control, or resort to abortion when facing unwanted pregnancy.

Women's can use contraceptives methods to challenge the standards of family planning programs. Hull and Hull (2021) note that Indonesian women use the pill continuously to stop their menstruation to be able to perform religious rituals. Bledsoe and Hill (1998)) research in the Gambia also illustrates this issue. They describe how Gambian women use injectables to increase the chances of a successful subsequent pregnancy after letting their bodies rest after past "obstetric failure" like pregnancy-related trauma or delivery complication. In the United Kingdom, Boydell (2010) describes how many women take a pill to have pleasurable sex, plan motherhood, and regulate their menstruation periods, rather than simply to prevent pregnancy. Some women use the pill to conceal or to avoid external signs of menstruation, such as heavy bleeding that requires changing planned activities, pain that forces them to take leave from work or mood swings that make one challenging to deal with (Boydell 2010).

As illustrated by the above examples, women use contraceptives for different reasons and in ways contraceptives are not initially planned to be used, highlighting their agency in this matter. This Women's agency is also manifested in managing their contraceptive use despite their male partner's power over them. Lopez (1998) shows that Puerto Rican women's living in the United States resist family planning services, reuse reproductive technologies as a means of empowerment in the face of male dominance. Stark (2020) has investigated in Bangladesh how women who have low autonomy are still proactive in taking contraceptives in secret, and often against community values, for their families' well-being and economic security. In sum, the

literature on women's contraceptive use illustrates that women are not passive in the face of biomedical technology, but instead make pragmatic choices, with responses ranging from acceptance to rejection or indifference (Lock, Kaufert, and Harwood 1998, Paxson 2002, Manderson 2012).

The literature on abortion reveals similar findings. Several studies demonstrate that social inequalities in accessing safe abortion services are driven by issues such as social, political, cultural, and economic determinants, unequal distribution of income in the population, restrictive abortion laws, stigma surrounding abortion, and difficulties in accessing and using contraceptives methods (Svanemyr and Sundby 2007, Ganatra et al. 2017). Moreover, despite restrictive abortion jurisdictions, the fact that many women still have abortions indicates a contested space where resistance to restrictive norms is present (Kumar, Hessini, and Mitchell 2009). Other authors have discussed the role that technology plays in the abortion debate and access by providing possibilities for interpretation or definition of practices surrounding the management of pregnancy (Wynn and Trussell 2006, Callahan 1986). Wynn and Trussell (2006) highlight how visual imagery's powerful effect contributes to transforming popular attitudes toward pregnancy, abortion, and personhood. For example, anti-abortion activists use ultrasound to maintain and convince women that the fertilized egg and foetus are each a new human being (Robertson 2011). In contrast, abortion rights activists expect that technologies such as manual vacuum aspiration (MVA) and medication that can terminate a pregnancy will be more acceptable for people opposed to abortion because they allow earlier pregnancy termination. Elaine Gale Gerber (2002) demonstrated how medical abortion, which expels the products of conception in early pregnancy, contributed to change French women's notion of abortion. Berer and Hoggart (2018) also described how the medical abortion pill could change how people relate to induced abortion, with misoprostol increasing women's autonomy in the abortion process because they can use the pills safely and effectively at home. This is in line with findings from several anthropological studies that have highlighted how the meaning of abortion can change depending on context and over time. The definition of abortion can be linked to expected and specified feelings (woman's right, a destructive act, part of the practitioner's work, a technical procedure, a positive action, murder) (Roe 1989). Other anthropologists have shown that the definition of abortion intimately depends on how personhood is defined by different people or cultures (Conklin and Morgan 1996).

By conducting ethnographic field work in the context of rural Thailand, Whittaker (2002) examines rural villagers' normative constructions of the act of abortion and the meaning associated with it. She shows that villagers can understand abortion as socially responsible and

ethical when reproduction becomes incompatible with other societal goals. In addition, she highlights how cultural understanding of foetal development can justify abortion at a certain period of pregnancy (before four months).

### Domestication

The theory of domestication directed my attention to the everyday practices of individuals who seek to acquire and use reproductive health commodities outside their formal, regulated circuits, uses, and applications, challenging consideration of technology adoption as a one-dimensional process (Wheeler and Wheeler 2009), Silverstone and colleagues (1992) originally developed the concept of domestication within the field of STS to describe the processes by which technology is appropriated by its users. They divided the process of domestication into four phases: appropriation, objectification, incorporation, and conversion. The appropriation phase refers to when an individual acquires a technical object and becomes the owner of it. The objectification reflects how the use of technology is embedded within the household and portrays the household's identity and values. The incorporation focuses on how the role of technology fits within the daily routine. The conversion phase indicates how technological objects transform the relationship between the household and the outside world through remaking meaning and norms associated with them (Silverstone, Hirsch, and Morley 1992).

The domestication of goods or technologies can be considered part of their “social life” (Childerhose and MacDonald 2013), questioning how goods and possessions enter people's lives and what symbolic meaning they then get (Haddon 2011). In other words, domestication refers to one aspect of the social life of things. The particularity of domestication theory is that it explores the complex processes of acquisition, adoption and especially the use of technologies into and in everyday life (Hynes and Richardson 2009). The domestication theory originated in the United Kingdom from anthropology and from consumption studies in the 1990s (Haddon 2011). Sørensen (1994) contributed to the development of the concept by examining the influence of social practices in the use and shaping of technical artefacts.

The notion has particular relevance in health-related research because it can help explain the gap between health policies and the behaviours of actors for which these policies are designated. Childerhose and MacDonald (2013) apply the theory in their study of how consumers create new uses for biomedical goods that were not intended by manufacturers or regulators and are not overseen by professionals. It is a notion that emphasises agency and resourcefulness in the adaptation of technology for one's ends. The concept of pharmaceutical diversion supported my analysis on the acquisition of reproductive health commodities. Pharmaceutical diversion refers

to the process in which, healthcare workers and pharmacists working in formal health settings are linked to networks of individual who can diffuse the product and knowledge about it (Lovell 2006). I referred to this concept to explain the movement of reproductive commodities from a formal and legal context to an illegal or illicit one.

## Conclusion

This chapter has summarised theory and literature relating to the concepts of the social life of things and the process of domestication, and the notion of reproductive governance, which directs attention to the historical and political context within which contemporary reproductive health practices play out. The literature on reproductive governance highlights the complex interplay of international and national actors and ideologies that determine the availability and distribution of reproductive health commodities in specific contexts. At the same time, attention to the pragmatism and agency of actors downstream of political decisions is necessary.

In the next chapter, I introduce the ethnographic background of my field site. I describe the social and economic context of Burkina Faso and of its capital Ouagadougou, where I conducted my fieldwork. I focus specifically on women's societal position and reproductive health, describe health service provision related to contraception and abortion and situate the history of reproductive governance within broader international trends.

## Chapter 3: Ethnographic background and reproductive governance in Burkina Faso

### Introducing Ouagadougou

Burkina Faso, a landlocked country in West Africa, has an estimated population of 20 million, 30.6 % of which lives in urban areas (Raghavan, Abbas, and Winikoff 2012, CIA World Factbook 2020). The population is predominantly young, with a median age of 17.9 years. Women of childbearing age (15-49 years), who are the target of reproductive health programs, represent 45.6% of the female population and 23.56% of the total population (MoH, 2015). The mortality of children under five years is at 87.54 ‰ (UNICEF 2021).

Burkina Faso is among the poorest countries in the world, with 44 % of its population living below the international poverty line of US\$1.90 per day (The World Bank 2019). Poverty affects Burkinabe women much more than men (Hagberg 2001). The economy in Burkina Faso is based mainly on agriculture, animal husbandry and trade, and depends on imports. The unemployment rate was 8.7% in 2014 among people between 15 and 24 years of age (CIA World Factbook 2020). In 2018, the total literacy rate (people aged 15 and over who can read and write) in the general population was 41, 2 %, and 50.1% among men and 32.7% among women (CIA World Factbook 2020).

My fieldwork, described in detail in Chapter 4, was carried out in Ouagadougou (often referred to simply as Ouaga and its inhabitants *Ouagalais*), which is Burkina Faso's capital and largest city. Historically the territory of the Mossi ethnic group, the city was originally known as *Woogrtenga* and *Wogodogo*, which means “where we receive honour and respect.” The population, which was estimated to be 2.7 million in 2015, is expected to reach 5.8 million by 2030 (United Nation 2014). Ouagadougou is Burkina Faso's economic and administrative centre, housing all the ministries, the presidency, the national parliament, and diplomatic delegations. Many international NGOs and local civil society organizations, working within health, education, trade, human rights, and the environment are also based there.

The city hosts one of the biggest markets in the country, called *Rodwoko*. Due to the business opportunities that it offers, Ouagadougou faces a significant flow of internal and external economic migrants. Half of its growth is estimated to be due to migration, mainly rural people moving into the city (Guengant 2009). The main languages spoken in the city are Moore and French, reflecting Burkina Faso's history as a former French colony. Muslims account for 60.5% of the population, Catholics 19%, animists 15.3%, Protestants 4.2%, and other religions 0.6% (INSD 2009), but in practice religious syncretism is frequent. There is even a saying that Burkina



Faso is 50% Muslim, 50% Christian, and 100% animist. Moreover, inter-religious marriages are very common, and religious leaders visit each other during various religious festivals. Several inter-religious associations work in the field of reproductive health. People of different ethnic groups and religions cohabit relatively peacefully, although the rise of Islamic insurgencies since 2015 has threatened this relative harmony (Afriyie 2019).

Ouagadougou is a place of meeting and exchange and is constantly animated by the movement of bicycles, motorcycles, and cars. The mixture of dust and exhaust combined with Harmattan winds can be unpleasant. It is not surprising to see donkeys in the middle of the traffic carrying bundles of wood or various goods. The shouting of vendors mixed with traffic and noise from the international airport, which is located close to the city centre. The city also organizes the festivities of *Festival Panafricain du Cinema de Ouagadougou* (FESPACO) film festival and *Salon International de l'Artisanat de Ouagadougou* (SIAO) (artisan festival), which are major biennial events in Africa, bringing together many international visitors and attracting traders, including traditional drug sellers, to set up shop in a merchant street.

Many people converge towards the city centre in the mornings, causing frequent traffic jams at rush hours (6:30 am to 9 am and from 4 pm until 8 pm). The roads are lined with trees that often serve as panels for commercial advertisements, information on upcoming events, and health awareness information. The crossroads and traffic lights of the city are spaces shared by beggars and street vendors, including young, male vendors of pharmaceuticals, whose peddling is considered illegal and is often tracked by the police.

In Ouagadougou, one can easily find food in street restaurants, commonly called in French *restaurant par terre*, priced accessibly at between 200 and 500 CFA Francs (less than 1 US Dollar). City officials, middle-class people, and foreigners often frequent upscale restaurants. Next to the restaurants, we have what the Ouagalais commonly call *maquis*, places where one can buy grilled chicken and fish and where, at night, alcohol flows freely. Maquis are very busy during the weekends. Many women from Ouagadougou, other cities, or neighbouring countries such as the Ivory Coast and Togo work as waitresses in the maquis from around 7 pm until the early morning. Some of them have relationships (not always sexual) with customers, from whom they receive gifts in cash or goods. In addition, female sex workers, referred to locally as *filles de nuit* circulate the street and often in front of hotels from around 10 pm, when the city centre begins to empty. The police often harass and arrest sex workers since selling sex is illegal.

There are significant disparities between the relatively well-equipped central districts and the peripheral districts of Ouagadougou, which consist of informal housing, lack equipment,

sanitation, water supply, electrification, and essential social services. This includes access to healthcare facilities, which are organised according to the health pyramid of the country and consist of primary, secondary, and tertiary health care. There are six health districts in Ouagadougou. For many reasons related to disparate urban growth, health districts manage populations of different sizes (Cisse 2007). Almost half of all private-sector health care facilities (229 out of 525) in Burkina Faso and are located in Ouagadougou (MoH 2015).

Like in Burkina Faso more generally, public healthcare in Ouagadougou is of poor quality with low involvement of the beneficiary populations (Ridde 2003). User fees have been a major barrier to access, often contributing to catastrophic healthcare expenditure that indebts households and interrupts livelihoods, especially pronounced for emergency obstetric care (Storeng et al. 2008). However, since April 2016, free care measures for children under five and pregnant women have been implemented in Burkina Faso, including post-abortion care, as part of a broader strategy to increase access to maternal and child health care and reduce maternal and infant mortality (Ridde and Yaméogo 2018). In the next section, I describe the status of women's reproductive health in Burkina Faso, before situating the governance of reproductive health in Burkina Faso within historical and international perspectives, and finally describing how this has shaped the provision of reproductive health commodities and healthcare.

### Women's position in Burkinabe society

Burkinabe women are traditionally appointed custodians of family welfare and health and are socialized into cleaning, sweeping, nursing, cooking, and caring for younger children (Storeng, Akoum, and Murray 2013). Most women are actively engaged in agriculture and the informal sector and are in a vulnerable position due to the temporal, seasonal, and unprotected nature of their work. Women often work outside the protection of labour laws and lack rights to social benefits. Therefore, they risk losing income due to pregnancy and childbearing (Guérin, Kumar, and Agier 2013). Poverty is a major obstacle to the access and use of health services (Ridde 2003, Haddad, Nougara, and Fournier 2006), and particularly affecting women (Storeng et al. 2008).

The social and cultural context is dominated by patriarchy, which leaves little margin for the empowerment of women in the management of their affective, sexual, and reproductive lives. However, some ethnic groups recognize the exclusive rights of women, which enhances their power within their family and society (Désalliers 2009, Kobiané 2007). Their access to healthcare services often remains the prerogative of their husbands and family (Marchal et al. 2005). Women's decision-making power related to reproduction also depends on gender relations. In a traditional setting of high fertility, some women cannot express their opinion and are often under

the domination of men (spouse, father, brothers, uncles, etc.). However, a different pattern is seen among young couples, where women discuss the desired number of children and the use of contraceptive methods with their partners (Andro, Hertrich, and Robertson 2002).

Marriage is a valued institution, widely considered as a sign of social maturity and responsibility, and an honour for the family. The average age at first marriage is 17.9 years, with almost a third of girls married between 15 and 19, and two-thirds of women married before the age of 24 (INSD 2012). Culturally, women receive an education that prepares them for their reproductive role as a spouse and mother. Discourses and practices regarding the prohibition of sex outside marriage are generally more focused on women (Bajos et al. 2013). However, although sexuality in marriage is valued, this cultural norm does not necessarily prevent sexual relations outside of marriage (Rossier et al. 2006). One of the elements that leads to premarital or extramarital sex is the weakening of the elders' authority over young people (Kobiane and Yaro 1996). Other possible explanations are the gradual abandonment of arranged marriage (Bledsoe and Pison 1994) or the hardening of the socio-economic context, which delays marriage (Calvès, Kobiané, and Martel 2007). Moreover, female strategies for finding a husband can also motivate young women to engage in relationships and then expose themselves to the risk of a pregnancy, which may lead to marriage but can also end in abortion (Rossier, Sawadogo, and Soubeiga 2013).

Young people often engage in sexual relations without adequate protection (Rossier, Sawadogo, and Soubeiga 2013) due to the difficulty of reconciling sexual spontaneity with contraceptive planning (Hoggart and Phillips 2011), limited access to family planning services (Bationo 2012), and misconceptions about the effects of contraception (Mejía-Guevara et al. 2020). This situation tends to expose them to unintended or unplanned pregnancies. Although motherhood occupies a fundamental place in the construction of female identity and conjugality (Bajos et al. 2013), the consequences of premarital pregnancies can be difficult to bear for women. However, the management of premarital pregnancies varies greatly from family to family and depends largely on the attitude of their male partner (Bertho 2016). When the woman's partner does not recognize paternity, it is experienced as a shameful event, which the woman's social entourage reminds her of with repeated reproaches and sarcasm (Ouattara and Storeng 2008). For example, in the Mossi ethnic group, a woman who is carrying a premarital pregnancy is generally driven out of her parents' house and goes to live with her aunt. A child born out of marriage (adultery or premarital) is sometimes indexed as a *yob biiga* (child of debauchery), when the father of the child is not known (Bertho 2016).

## Reproductive health governance in Burkina Faso

Various national laws, regulations and policies seek to regulate women's reproductive lives, contributing to relatively good access to contraceptives, but maintaining abortion as moral deviance, and to be socially and legally condemned.

The government, international institutions, international NGOs and local organisations share a commitment to increasing the general modern contraceptive prevalence (KI 2017), while trying to reduce the burden of unsafe abortion through family planning and PAC services (Storeng and Ouattara 2014).

As a former French colony, Burkina Faso inherited a restrictive legislative framework on contraception and abortion. Until 1970, abortion and family planning in Burkina Faso was governed by the French law of 1920, which prohibited abortion and the distribution of contraceptives (Mayhew, Osei, and Bajos 2013). In France, the law aimed to fight against low birth rates at the end of the First World War (Engeli 2007), while its imposition in colonised countries was to have an abundant workforce (Weil and Dufoix 2005).

At the population conference in Bucharest in 1974, during the post-colonial period, there was debate about introducing policies aimed at reducing population growth, which was seen as a break on development. Burkina Faso shared the idea with many African countries that “socio-economic development is the best contraceptive” (Lesthaeghe 1989) and did not introduce family planning in development policies. In 1978, Burkina Faso endorsed the Alma Ata Declaration, which included an aspiration to provide “health for all through primary healthcare”, with comprehensive, universal, equitable, and affordable healthcare service in all countries (Hall and Taylor 2003). Primary healthcare included a strong focus on maternal and child health, a key component of family planning. However, following the recommendations in the Alma Ata Declaration, the government drafted its first program on maternal and child health, which focused more on nutrition-related issues than family planning (Weil, Munz, and Tapsoba 2004) .

The institutional and political environment of family planning in Burkina Faso began to evolve in the 1980s to adapt to various African and international population conferences (Arusha and Mexico in 1984). During the population conference in Mexico in 1984, many countries agreed on reducing fertility and designing population policies (McFarlane 2014) . The first significant act by the government of Burkina Faso was to create a National Population Council in 1983, with the mission to propose a population policy following the country's social, economic, and cultural situation. That happened in a context where the World Bank and other financial institutions became increasingly involved in international health funding and policymaking (Birn 2009).

Under the influence of the World Bank, family planning services were initiated under the leadership of the Burkina Faso Association for Family Welfare (ABBEF) and the Midwifery Association of Burkina Faso (ASBF), with support of their international partners such as the International Planned Parenthood Federation (IPPF) and the USAID (Tankoano 1990). In addition, a bilateral project was set up between Burkina Faso and USAID to support family planning activities. The project included advocacy for revising the French 1920 law prohibiting the sale and advertising of contraceptive products (Tankoano 1990). This legalized the availability of contraceptives in public healthcare structures. The bilateral project also allowed the introduction of education on family planning issues in schools, the recognition of associations carrying out family planning activities, and the adoption of various projects to develop family planning (Duboz and de l'ORSTOM 1992). To obtain contraceptives, women had to undergo costly laboratory tests, which were a barrier to access. Having noted this issue, the government decided in 1988 to authorize women to purchase oral contraceptives without routine laboratory testing (Mayhew, Osei, and Bajos 2013).

At the beginning of the 1990s, the international debate was pervaded by the conviction that population growth in the global South was the root cause of worldwide environmental degradation and called for countries to institute policy actions to overcome the issue (Correa, Reichmann, and Reichmann 1994). Therefore, Burkina Faso adopted a national policy in 1991 in which the state recognized the importance of population issues and the challenges they pose to development (Weil, Munz, and Tapsoba 2004). The objective of this policy was to reduce the infant and maternal mortality rate, increase the rate of contraceptive use and consequently achieve up to 10% annual fertility decline by 2005 (Mayhew, Osei, and Bajos 2013). The population policy fostered changes in the institutional and political environment for development. From this perspective, in 1993, the government developed a national plan to promote primary health care, organize the health system into districts, and establish a national buying agency for essential generic drugs. (Ridde 2003).

### **The influence of the ICPD in Burkina Faso**

The International Conference on Population and Development (ICPD) in Cairo in 1994 brought a notable change in family planning policies by broadening the agenda and addressing a range of sexual and reproductive health issues that are part of the individual lives of men and women (Roseman and Reichenbach 2010). As discussed in Chapter 2, the conference introduced the rights-based approach to family planning by emphasizing freedom of choice, right to health, equitable service delivery, accountability, and empowerment through the concept of reproductive health and rights. This approach ran strongly against coercive approaches that had been a

cornerstone of population control efforts in the decades before (Hardee et al. 2014). Reproductive health was defined as a state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes (Cook and Fathalla 1996). The concept of reproductive health and rights implied that people could reproduce, have a satisfying and safe sex life, and the freedom to decide if, when, and how often to do so (ibid).

The ICPD Program of action stressed the need for quality family planning services, attention to safe pregnancy, sexually transmitted diseases and infections, and the problem of unsafe abortion, and called for programs for adolescents and men (Hempel 1996). Following the ICPD, the government of Burkina Faso adopted the concept of “reproductive health and rights” within its policy discourse, and revised national policies and standards on family planning to include the right of individuals aged 18 and over to access family planning service. In 1996, Members of Parliament amended a penal code that authorized abortion at all stages of pregnancy when the woman's life or health is in danger, in cases of severe foetal malformation, and during the first ten weeks of pregnancy in cases of rape or incest (Weil, Munz, and Tapsoba 2004). The ICPD also seems to have motivated the government to implement Post Abortion Care (PAC) to address complications after abortion, initially through a pilot intervention designed by gynaecologists in partnership with international NGOs in 1997 (Ouattara and Storeng 2014, Ouedraogo and Juma 2020) and then gradually scaled up to referral facilities and later to primary health facilities (Ouedraogo and Juma 2020). The implementation of PAC, which relied heavily on the introduction of manual vacuum aspiration (MVA) to treat incomplete abortion, was supported by the American NGOs JHPIEGO and Engender Health, and the United Nations Population Fund (UNFPA) (Dieng et al. 2008).

### Reproductive health in the MDG era

In 2000, the Millennium Development Goals (MDGs) were established as a response to many of the world's foremost challenges (e.g. financial crisis, the decline of post-Cold War aid budgets, the HIV pandemic, maternal mortality) (McArthur 2014). The removal of retained products of conception through post abortion care was part of the global strategy to reduce maternal mortality (Van den Broek and Falconer 2011). Burkina Faso adhered to the MDGs' principles and revised its National Population Policy in 2000 (Guengant 2011b). This revision stressed the importance of promoting reproductive health services. The specific objectives for reproductive health included increasing access to modern contraceptive methods and encouraging increased use of reproductive health services. The revised policy also extended operations to the promotion of women's rights and education and the fight against domestic violence and sexual abuse (Weil,

Munz, and Tapsoba 2004). In 2005, the government adopted a reproductive health law that recognized the right to reproductive health as a fundamental right guaranteed to every human being and called on society to safeguard, promote and protect this right through assistance, advice, information, education, and communication (MoH 2010a). However, it authorized the voluntary termination of pregnancy only in the circumstances already mentioned in the penal code of Burkina Faso (Amnesty International 2009).

In the 2000s, the AIDS pandemic received a large share of programmatic attention and resources, which diminished the interest in family planning services and programs both at the global and national level, including in Burkina Faso, where the government depended heavily on external donors (Samoff 2004). However, in 2010, the global community re-focused attention on family planning as key to the achievement of the MDGs (Horton and Peterson, 2012), enhancing the visibility, availability, and quality of family planning services for increased contraceptive use (WHO 2008).

In 2011, nine governments of French-speaking West African nations, including Burkina Faso, convened a Regional Conference on Population, Development, and Family Planning in Ouagadougou, founding the Ouagadougou Partnership. The partnership lobbied for the improvement of policy and legal frameworks in its member nations, the strengthening of funding mechanisms, and the dismantling of sociocultural obstacles to women's reproductive health, with the aim of expanding family planning service usage by at least 2.2 million extra users by 2020 (Bendix et al. 2020).

The present political discourse on development is supported by demographic goals and asserts that infant mortality has decreased significantly in Burkina Faso over the previous 25 years, although maturity rates have stayed reasonably high with a dropping rate. United Nations' (UN) predictions indicate that there will be more than 40 million people in 2050. Thus, the optimal scenario for Burkina Faso's economical rise would be to concentrate efforts on a mix of increased investment in family planning, economic reforms, and education (Guengant 2011a). By 2054, the remedies offered at the family planning reform level will be to boost the percentage of contemporary contraceptive usage to 62.9 percent. Mobilize domestic resources to fund reproductive health, including the annual maintenance and expansion of the budget line devoted to the purchase and logistics of contraceptives, in order to avoid or eliminate financial shortfalls. Maintain and accelerate the existing decline in infant death rates via immunization, integrated childcare, nutrition, and the use of insecticidal mosquito repellents.

## Family planning services and commodities

In Burkina Faso, many initiatives attempted to boost family planning by implementing a Strategic Plan for the protection of reproductive health commodities (2009-2015), as part of the repositioning of family planning within the MDGs. The strategy's goals were to avoid stock-outs, reposition family planning as a priority action in the national health development program (2011-2020), and improve access to family planning services by providing free family planning service delivery, subsidise modern contraceptive methods, provide community-based distribution of contraceptive products, establish community radios and distribute information, education and communication material on family planning services. The government also set up national family planning weeks every semester to increase the use of family planning services (Kaboré et al. 2020).

In 2013, the government, with technical and financial support from USAID, initiated a delegation of family planning tasks to involve community health workers in providing services (Konaté et al. 2015). This initiative also responded to a WHO recommendation to address the shortage and uneven distribution of the health workforce. The Ministry of Health entered a contract with NGOs such as ABBEF and Marie Stopes International (MSI) to set up community-based distribution of contraceptives, including in remote areas where access is difficult. Community health workers were responsible for awareness-raising activities and distribution of condoms and resupply of oral contraceptives at the community level (MoH 2010b). Auxiliary nurses or auxiliary midwives were authorised to provide short-acting contraceptive methods at the primary healthcare centre level, including injectable contraceptives, and medical doctors and midwives to provide the implants and IUDs. Surgical methods were to be provided by medical doctors or by *attaché de santé* (midwives and nurses who are trained to provide surgery), who would also offer advice on 'natural' methods of family planning. At the same time, pharmacists would be responsible for providing family planning and abortion care commodities to health care facilities. While these public sector workers would be guided by the standards and protocols established by the Ministry of Health (which follow the norms set by WHO (WHO 2010), health workers in private, denominational Catholic sector were known to limit their action to offering specific types of contraception that are acceptable within religious doctrine (e.g., natural contraceptive methods).

The relatively low uptake of contraceptive services despite these policy initiatives seems to reflect ambivalent attitudes towards family planning commodities. For example, a qualitative study on the use of contraceptives by women in rural Burkina Faso describes that they are reluctant towards modern contraceptives because they fear adverse side effects, notably menstrual cycle disruption (Bakyono et al. 2020). A four-country study from Burkina Faso, Senegal, Ghana and Morocco similarly showed that contraceptive methods like the pill, injection and implant



(contraception that contains hormones) invoke fear of infertility, with women who nevertheless decide to use them occasionally limiting the dose of hormones ingested in their body (Bajos et al. 2013). Storeng et al. (2010), qualitative research with women who survived life-threatening obstetric events in Burkina Faso shows how they often use contraceptive methods to ensure rest and recovery as a strategy for ensuring a successful future pregnancy. However, some women use contraceptives covertly, because delaying pregnancy openly will excuse their husbands to take another wife or initiate extramarital sexual relationships (ibid). Other studies in Burkina Faso describe that women do not accept contraception as the only means of managing their fertility. Some women use abortion as another alternative method for controlling their fertility, despite its legally restricted nature in Burkina Faso (Baxerres et al. 2018b, Bankole et al. 2013, Ouédraogo and Guillaume 2017, Rossier 2007).

### Abortion commodities and post-abortion care

Although abortion is technically legal in some circumstances, in practice, the provisions allowing women to terminate a pregnancy have been complex and challenging to meet. The requirement that two doctors must attest to the danger of continuing the pregnancy has often been an insurmountable obstacle, especially for women living in rural areas where there is a lack of physicians. In cases of rape or incest, the public prosecutor's requirement to establish the crime committed appears to be a strong deterrent condition in a context where victims face severe risk of stigmatisation. In addition, women's knowledge of the legal status of abortion is low: Only about one-third of Burkinabe women are aware that abortion is legal in some cases (Bankole et al. 2013).

Despite abortion's contested status in Burkina Faso, a consensus was reached in the 1990s on introducing PAC in health programs and health facilities as part of safe motherhood services. This was because national decision-makers, doctors and nurses who were hostile to induced abortion had been convinced that PAC was 'lifesaving care', which should be delivered for medical ethical reasons (Storeng and Ouattara 2014). In addition, PAC was supported because it provides a partial solution to unsafe abortion without requiring any change in abortion legislation (Storeng and Ouattara 2014). When it was introduced into the health system, PAC was only offered by medical doctors before gradually being the subject of a delegation of tasks to involve midwives and auxiliary midwives in the treatment of incomplete abortion (Dieng et al. 2008).

In 2006, the government of Burkina Faso introduced the national subsidy of obstetric care (Amnesty International 2009) and in 2018, the Ministry of Health (MoH) began implementing free maternal healthcare that included PAC services (Ouedraogo and Juma 2020). The

government also increased the number of trained medical personnel and sought to enhance their skills to improve the quality of obstetric care (Amnesty International 2009). However, a considerable contribution to strengthening PAC services came from NGOs, notably ABBEF and MSI, who provided material support for PAC services, trained public sector health workers in clinical PAC skills, operated private clinics to supplement public services or supported local NGOs (Storeng and Ouattara 2014)..

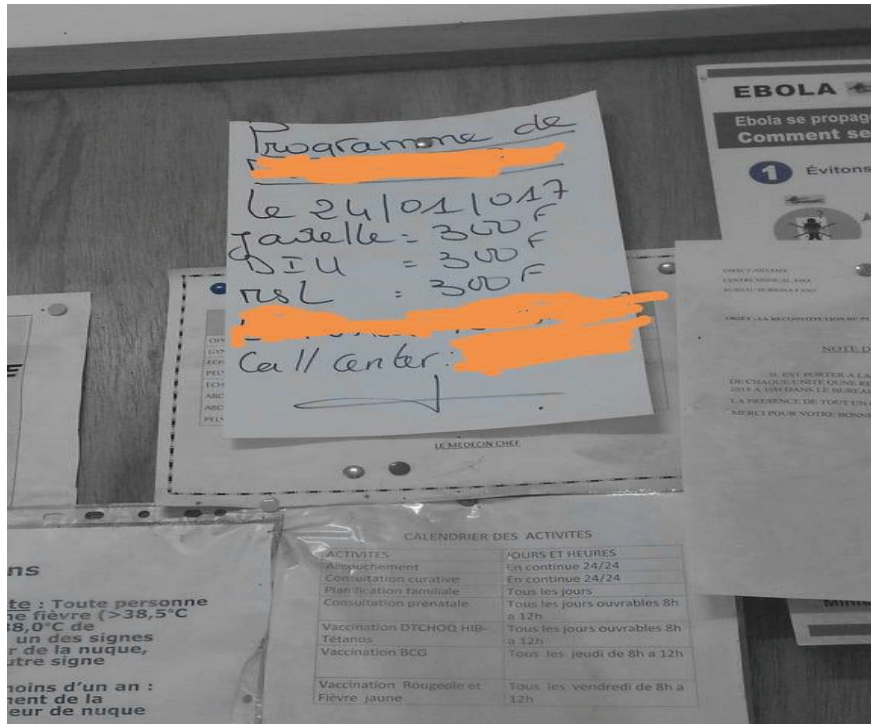


Figure 1: An International NGO's announcement about the supply of contraceptive method

PAC includes dimensions such as counselling and links with other reproductive health services and the community, treatment for incomplete abortion (induced or spontaneous) and prevent unsafe abortions through family planning and public dissemination of policies and laws (WHO 2003). Before 1992, incomplete abortion involved dilation and curettage or digital removal of uterine content, but PAC programmes replaced these with less invasive MVA.

Although misoprostol has been used for abortion purposes in the mid-1980s in countries with restrictive abortion laws (especially in Latin America), the WHO only recommended its inclusion in the list of essential medicines in 2005, with use subject to countries' legislation (WHO 2012). Misoprostol's introduction in Burkina Faso has been the subject of several negotiations between NGO actors, healthcare professionals and Ministry of Health officials, resulting in its inclusion in the list of essential medicine in 2014 to treat postpartum haemorrhage and post-abortion care (as

part of PAC services), though not for the termination of pregnancy Its use has largely occurred outside formal health facilities, as I describe in Chapter 5.

### Conclusion

The chapter has presented the social, cultural, economic and political context of reproductive health in Burkina Faso, showing how women's financial situation and the social and cultural life in Burkina Faso, and provided a historical overview of policy development relating to family planning and abortion. It showed how these two phenomena have evolved between prohibition, restriction and promotion with global health policies and reproductive health-related legislation. The chapter described the different actors involved in providing family planning and abortion services and the commodities available. In the next chapter, I describe my methodology for studying the use of these commodities.

## Chapter 4: Methodology and Ethical Considerations

### Introduction

My thesis is based on ethnographic research. Ethnography is defined as a social research method that draws on a wide range of sources of information, collected by an ethnographer who participates in people's daily lives for an extended period of time, watching what happens, listening to what is said, and asking questions in order to understand an issue under research (Atkinson 2007).

The meaning and experiences of individuals are complex and can depend on many factors and contexts that cannot be understood with standardized data collection procedures such as surveys (Atkinson 2007). The ethnographic approach allowed me to adapt the research process to the social context and unexpected challenges inherent to fieldwork. In addition, the diversification of sources of data and information allowed me to hear multiple voices and integrate several perspectives essential for understanding social reality.

My ethnographic research took place in the lifeworld of women, healthcare workers, drugs vendors, and policy actors, based on fieldwork conducted in Ouagadougou during two periods between 2015 and 2017. The first period (October 2015 to December 2015) was enabled by a six-month research assistantship enabled with the INFODOS research project on computerisation obstetric files in a sentinel maternity network in West Africa, facilitated by my co-supervisor Fatoumata Ouattara, one of the co-investigators. Findings on healthcare workers' use of misoprostol in health care centres in Ouagadougou fed into the book chapter (Paper II) submitted as part of this thesis and an article produced by the INFODOS project (Ouattara et al. Forthcoming). In the second period of fieldwork (March 2016 to February 2017), I focused on women, healthcare workers and drug vendors' experiences with reproductive health commodities.

### Conducting sensitive research and ethical issues

Ethnography is a useful method to explore sensitive topics because it can provide rich, detailed descriptions about the unknown or the little known (Li 2008). Renzetti and Lee (1993) identify four potential threats that allow research to be considered sensitive. The first threat emanates from the study of private or highly personal experiences. The second threat comes from research on behaviour deemed deviant by society. A third threat can come from issues related to power and domination. A fourth threat comes from issues considered sacred so that the discussion about them is deemed taboo.

My research was sensitive because it addressed several controversial issues and illicit behaviours, such as the illegal sale of abortion drugs, illegal abortion, and prostitution, and, more generally,

people's intimate reproductive and sexual life. I dealt with some people living at the margin of societal norms, who might face stigma if their lived experience is publicly revealed.

Before starting my fieldwork, some fellow students, health professionals, and friends I discussed my research project warned me of the risks studying socially sensitive issues of my research. They said things like: "Because of my religious faith, there are certain subjects that I avoid"; "The subject is interesting, but you don't know how your results will be used"; "Are women going to listen to you". They questioned me about my values and identity as a person rather than my status as a researcher. My previous experience studying sensitive topics gave me confidence to proceed, though with close attention to the choice of research methods, ethical issues and participants' vulnerability (Hobbs 2001).

Research raises both questions of procedural ethics and ethics in practice (Guillemin and Gillam 2004). Procedural ethics encompasses norms, standards, and procedures related to the ethical planning and conduct of research, and the responsibilities of researchers. Ethics in practice, in contrast, involves the types of embodied ethical issues that arise in the everyday activities of carrying out a research project and the interactions of researchers with participants and other people within and around the research process (Guillemin and Gillam 2004). Procedural ethics does not necessarily address the ethical challenges of conducting research with impoverished, vulnerable populations, which require personal moral integrity from the researcher (Molyneux and Geissler 2008), as well as mindful awareness of and frequent adjustments to ongoing relationships (Li 2008).

The procedural ethics in my research followed two stages. First, submitting my research protocol for approval to the Norwegian Social Science Data Service (NSD), which assesses researchers' plans for collecting and storing personal data in compliance with privacy, right, and to the Ethics Committee of the Ministry of Health in Burkina Faso (see approvals in appendix). The second step involved obtaining authorization to carry out my research in health facilities from the Ministry of Health, which also brokered access to other actors working in associations, NGOs, and international institutions. The protocol submitted to the ethics committees and the administrative letters included directives, which I should respect in my interaction with participants, relating to consent, confidentiality, risks, privacy rights, and protection from harm in my interaction with my research participants.

I obtained written or oral informed consent for all those who participated in in-depth interviews (see below). For my observation in healthcare facilities, access to the settings was done after getting the facilities' approval from person in charge of them and then later negotiate access to

people in these setting on the daily basis depending on who I met, similarly to other researchers approach to observing practices in healthcare facilities (Mays and Pope 1995, Mulhall 2003). In healthcare facilities and in other places where I carried out fieldwork (e.g., pubs and markets), I took care to introduce myself and to present my study informally while justifying my presence on the sites. This approach is consistent with the guidelines for ethical conduct in participant observation that suggests that the researcher should resort to general announcements or other more informal means to disseminate his identity and purpose among people, rather than obtaining formal written consent (Takyi 2015).

I did not offer any special financial incentives to participate because cash payments, which reimburse or compensate for time and inconvenience, are not considered widely accepted in international guidelines (Molyneux et al. 2012). However, where relevant, I reimbursed travel expenses as is customary in Burkina Faso.

Below I describe the specific qualitative research methods I employed as part of my ethnographic research, including review of documents, such as scientific published articles and books, national and international policy documents on family planning and abortion and participant observation and in-depth interviews. I describe the participant observation and the in-depth interviews in detail in the next section paragraph.

### Participant observation

Participant observation is a research strategy that aims to explore phenomena as they emerge in interactions between people in a given context (Moen and Middelthon 2015). I decided to conduct participant observations in different places (pubs, healthcare facilities, market places, and workshops) to observe how reproductive health commodities were being sold, prescribed or used, an approach used in other research into the ‘social life’ of medicines (Hardon, Hodgkin, and Fresle 2004).

I observed pubs along the streets of Kwame Nkrumah, the main thoroughfare with many hotels, restaurants, pubs. I spent some evenings sitting with women in pubs after buying drinks because I could not occupy a sit in pubs without consuming food or beverages that they sell. These moments allowed me to start conversations around the issue of abortion and to negotiate in-depth interviews with some of the women who worked as waitresses in bars or as sex workers.

To understand the context of drug sales and the interactions between drug sellers and consumers, I conducted observations in places where street drug vendors sell their products. I spent hours in the store of one of the drug vendors selling contraceptives methods made of herbal (often called traditional contraceptives) and other drugs. The long hours spent waiting there (3 to 6 hours)

allowed me to discuss with the drug vendor and some of his clients. When the vendor was absent for short period of times, he used to ask me to make his customers wait until he returns, which allowed me to engage in conversations with them.

I observed contraceptive services and the interactions between healthcare workers and women during group counselling on family planning in three different places. Besides, I observed an international NGO working with family planning during one of their contraception campaigns in one primary healthcare centre. I also participated as an observer in two “value clarification” workshops on abortion in Ouagadougou with healthcare workers and members of the Parliament of Burkina Faso. My participation in these meetings allowed me to negotiate interviews with people working in family planning and abortion.

Participant observation is a way to become familiar with the assumptions and rules of the social environment under scrutiny (Porter 1991), and to describe existing situations to provide a thick understanding of the situation under study (Erlandson et al. 1993). In other words, participation offers the opportunity to learn through seeing, listening, talking, discussing, feeling, touching, moving, and doing (Moen and Middelthon 2015). The flexibility of the ethnographic approach allowed me to move from one space to another depending on the evolution of events and my focus, sometimes taking photos of posters or advertisements related to family planning (Figure 2). I also relied on informal discussions, a helpful method, given the sensitivity of the topic, as its low-pressure interaction allows respondents to speak more freely and openly than a formal interview. I had informal discussions with a range of actors, including policy actors, pharmacists, healthcare workers, women, around family planning and abortion. The material from these discussions were part of my daily field notes and helped me identify themes for more structured investigations through in-depth interviews.



Figure 2: advertisement for “traditional contraceptive methods” in Ouagadougou

## In-depth interviews

In-depth interviews are intensive individual interviews with research participants to explore their perspectives on a particular idea or experience. They are helpful to get detailed pieces of information about a person's thoughts and behaviours or explore new issues in depth (Boyce and Neale 2006). Individual in-depth interviews are characterized by their degree of flexibility and openness that allow incorporating emerging themes and topics as they arise, both during each interview and during the study itself (Moen and Middelthon 2015). I interviewed 86 individuals, including 46 women, 36 healthcare workers, and five drug vendors.

The 46 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 sex workers, three cleaners, and one maid. Twenty were married, six were cohabiting with a male partner, and eighteen were single (not in a stable relationship), one divorced, and one widowed.

The 36 healthcare workers were from different levels of healthcare facilities, including University Hospital Centres, district hospital/medical centre, and primary healthcare centres in public (11 facilities including one university hospital, one district hospital<sup>2</sup>, nine primary health care centres) and private facilities (seven facilities including four medical centres and three primary care centres). They included gynaecologists, midwives and auxiliary midwives working in maternity care units. 14 people among these healthcare workers oversaw family planning and post-abortion care services. The five drug vendors included one vendor in a private pharmacy and four vendors who work in the street and marketplaces.

I used a topic guide (see appendix) that included topics and questions for open-ended discussion, rather than being semi-structured guides. The interview with women explored their individual reproductive health histories and future reproductive intentions, their perceptions and practices on contraceptive methods and abortion methods, and the decision-making processes and networks involved in procuring an abortion. The interview with the healthcare workers and drug vendors explored their perceptions and experience using contraceptives and misoprostol. I conducted the interviews in French, Moore or Dioula. They lasted between 20 and 90 minutes and took place in healthcare facilities, a Public Park, home of participants and an office that I was using in a research centre. Data from the interviews have been recorded through an audio recorder and note-taking and were stored in a file on my private computer. The recordings have been

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<sup>2</sup> The district hospital became a university hospital after my fieldwork.



transcribed. The strategy I used to reach some of the research participant was based on intimate ethnography and ethnographic capital.

### An 'intimate ethnography' and ethnographic capital

By deciding to study the social uses and significance of reproductive health commodities beyond their normative definition, I decided to approach my field in the most flexible way to integrate several perspectives. Long-term immersion helps the ethnographer learn the basic beliefs, fears, hopes, and expectations of people under study. To access my participants and to collect data, I did what several ethnographers have called an intimate ethnography (Waterston and Rylko-Bauer 2006, Salhi 2013). An intimate ethnography is an ethnography during which my participants are more or less close to the researcher. The difficulties that I encountered at the beginning of my fieldwork drove my choice of this approach mainly used to reach some women.

The idea that a woman would be more comfortable talking to another woman on topics referring to her sexual and reproductive life (DiIorio, Kelley, and Hockenberry-Eaton 1999) rather than to me as a man constantly came into my mind before I started approaching women for informal discussions and interviews. I have lived in Ouagadougou previously and know it intimately. In addition, I had experience interviewing women on maternal and reproductive health-related issues from my previous research projects. However, neither were a guarantee to access women willing to talk about their intimate reproductive and sexual lives. I planned to contact and interview some women outside of healthcare facilities because I wanted to speak to both users and non-users of family planning services. My first attempt to talk about my research to a woman in the streets of Ouagadougou was difficult: she told me that because I am a man, she would have been more comfortable talking about Ebola than reproductive health-related issues. This was a big challenge for me since I knew that close relationships and talking to people are key dimensions of ethnography (Hoarau 2000).

To overcome these difficulties, I decided to start by interviewing people in my social network, including neighbours, friends, colleagues, and friends of friends. I seized opportunities to ask if I could interview them about their experience during informal interactions. These friends and acquaintances tolerated my intrusion into their privacy because it occurred in the context of research. As one of my participants said "Humm, you are too curious. It is because I know you are doing your research on these issues. Otherwise, you would never know about me".

An intimate ethnography often establishes a less formal relationship between a researcher and his participants. Still, it can also lead to a relaxation in the research protocol and the rigour during data collection (Salhi 2013) that can compromise the quality of the fieldwork. Therefore, the

challenge for me was to transform established friendly relationships into ethnographic relationships. In other words, it was about how to create this distance that allows me to better 'observe' my participant. I adopted the strategy to establish a formal research relationship, including respecting the rules of ethics that are done before every interview (presentation of the study project, inform consent, asking permission to record, etc.). This strategy contributed to establishing a more 'professional' relationship with those women I wanted to interview. I also decided to talk to them by using formal pronouns to mark a symbolic distance by turning a friendly ambience into a formalized relationship (In French, *tu* is informal and singular, while *Vous* is formal and/or plural). By adopting this strategy, I had to use the sentence "you and your husband" in case I wanted to refer to a couple's decision-making choices to avoid confusion. This nuance is very relevant to avoid confusion during data collection that involves couples in the context where an interview is conducted in French or languages that use a similar courtesy expression. This shows how understanding language codes and knowing how to exploit them in conversations with research participants is important in data collection.

With time, I decided to shift from my relatives and friends to include other people I do not necessarily know, to avoid being focused only on a specific social realm (Papadaniel 2008). For this purpose, people in my surroundings connected me with other women: their friends, relatives, etc. Through this approach, I met the *filles de nuit* (sex workers), abortion providers, and drug vendors who sell drugs in pharmacies or the street, including contraceptives or misoprostol. The *filles de nuit* are regularly in contact with healthcare workers for routine medical visits. Some of them act as an intermediary between health workers who provide clandestine abortion services. From the abortion workers, I had contact with three healthcare workers who acknowledged providing illegal abortion. Still, only one of them was willing to participate in an in-depth interview.

I also sought to recruit women for in-depth interviews from a health centre providing family planning of PAC, as I had experience with from my MPhil research on access to PAC in Ouagadougou (Drabo 2013). I depended healthcare workers' assistance to identify and recruiting women from family planning and abortion care services, after obtaining written approval from the Ministry of Health to conduct my research in healthcare facilities.

Before starting my fieldwork, I feared that healthcare workers and people working in the Ministry of Health, in international organizations, and in NGOs who may not be interested or available due to their busy schedules. However, I made recourse to the knowledge, data, social relationships, and social networks that I acquired in my previous ethnographic research to access them. I refer

to the uses of this previous ethnographic resources as ethnographic capital. Therefore, my ethnographic capital allowed me to participate in conferences on abortion-related issues that served as venues for observations. For example, I attended a conference in Addis Ababa, in which I met policy actors, researchers or activists working in the field of abortion, especially the seven delegates from Burkina Faso.

In addition to giving a presentation on the issue of access to post-abortion care based on my master thesis, the conference organizers chose me to read the final report of the conference at the closing session. Therefore, my participation was very active and allowed me to interact with several actors through informal discussions. As a new member of a network of actors interested in this question of abortion in Africa, I was able to get interviews from my fellow Burkinabe once we returned to Burkina Faso. They also put me in touch with their colleagues from other NGOs and international institutions working in the field.

Another way I used my ethnographic capital was to build new relationships based on the social connections I made during previous ethnographic research. For example, after my investigations in healthcare facilities, I kept in touch with certain health workers through emails or phone calls. Going back to the same facilities after some years was like returning home. One day in one of these health centres, one of the health care workers I met said, "at least you are not like some people who disappear after getting what they want". Even if my contacts were not necessarily my potential informants, they made it easier for me to meet certain people I wanted to interview by giving me their telephone number or their schedule so that I could meet them. This was of great help as I had previously experienced that people may consent to participate in an interview but then do not show up.

### **Informed consent**

All the individuals who participated in in-depth interviews provided informed consent. Obtaining informed consent can be part of a process that takes place over time. Some respondents need time to understand and consider the researcher's intentions before accepting an interview, for example. A well-drafted information letter and informed consent form approved by an ethics committee may prove to be insufficient to reassure potential research participants about the risks and benefits involved in research participation.

Before starting an interview, I read aloud the information letter and informed consent forms to the participants. NSD in Norway and the ethical committee in Burkina Faso do not set requirements on whether consent should be given in writing or orally. Most of the participants I formally interviewed preferred to provide oral rather than written consent. This was primarily

due to the sensitivity of the topic for both the healthcare workers and women. For example, some health workers used to say: "are you interested in what I will say, or it is my signature you need." Other health workers who were already used to 'the ritual' of reading the informed consent form did not let me finish reading the document. They used to say: "if I am here, it is because I already consent to participate"; "maybe we should start because I have a patient who is waiting". Women also felt more comfortable giving oral consent than written consent when asked to do so, as in other ethnographic research undertaken on abortion in Burkina Faso (Ouedraogo and Sundby 2014, Ouedraogo, Senderowicz, and Ngbichi 2020). They manifest the consent by saying "there is no problem" or by a gesture of the head indicating their agreement to grant me an open-ended interview. Some people expressed that they were not willing to participate in my research by blocking my number so that I could not call them again to have an interview after giving their consent to participate.

Other women participated in an interview after giving their explicit consent but decided to 'cook' or fabricate stories, because some of them stated they initially felt pressured to participate in the interview. Moreover, the relationship that I had with my participants allowed some of them to be more comfortable and willing to divulge their experiences. For example, I met a woman using my network who agreed to be interviewed. She was, however, very reserved during the interview and decided not to mention her abortion experience. However, afterwards, she unexpectedly called me to meet her for another interview to "tell me the truth" about her abortion experience. Therefore, we had a second interview with a new story different from the first one. After the discussion, she decided to open up to me, confiding that she was moved by the way I treated her (respect and courtesy) and because her sister reassured her that I was a doctoral student by showing her my business card.

### Confidentiality

In conducting socially sensitive research, one of the major problems is the confidentiality of the information revealed to the researcher (Sieber and Stanley 1988). The issue of confidentiality revolves around three points: The management of a potential risk linked to the disclosure of secrets, the protection of the identity of participants, and confidentiality about the use of information obtained without authorization. In-depth interviews, which are open discussions, can involve ethical dilemmas that are difficult to predict. An interview is usually equated with confidentiality and the sharing of secrets (Orb, Eisenhauer, and Wynaden 2001). A participant can share information, which may be of vital relevance to research, but revealing the information through publication, for example, could also put the informant at risk. This creates a dilemma, leading the researcher to position himself and balance the interest of the research and

that of the participants. For example, during my research, I spoke with a healthcare worker who admitted to carrying out illegal abortions. During our discussion, he shared with me information on abortion that was supposed to be secret, according to him. The information he gave me was rich material to understand my research topic's social and political issues. However, for confidentiality, I preferred not to exploit that information at the risk of putting my respondent in delicate situations. To protect my informants' privacy, I anonymised their names, referring to them in my writing with fictional names or their professional identity.

### Reflexivity: negotiating my identity as a researcher

When studying a group of people involved in socially disapproved activities, a researcher must assume social roles that fit into their worlds (Adler and Adler 1987). The relationships I had with my participants were both professional and social, a kind of double relationship that obliged me to play or assume several roles and respond to my participants' requests. In this context, it happened that some misunderstandings between me and some women compromised the field relationship. For example, one day, one of the *filles de nuit* insisted that we go to a hotel room so that she could give me the information I wanted. I did not do that because I did not want her to think that my purpose was the 'usual one. After this incident, I did not get any further contact with her.

In other cases, I obtained interviews with women through several efforts and sacrifices because some of them lived in places that were not conducive to an interview. I used to pick them up with my motorbike to find a suitable place for an interview, such as a private garden and bring them back when the interview was over.

Unpleasant feelings can lead to emotions that can cause a researcher to abandon or leave his fieldwork prematurely (Corsino 1987). Indeed, given the uncertainty and complexities of social interactions, participant researchers should not assume certain fixed positions at the field entry and then cling to them from start to finish (Li 2008). In my case, I moved from one setting to another setting, meeting different people and maintaining several positions, which allowed me to manage or bypass unexpected events that could have compromised the fieldwork (Corsino 1987).

I also faced role reversals, where I found myself in the position of a participant. One day a group of women I used to visit in a restaurant took my recorder from me, and one of them started interviewing me by asking the central questions of my interview guide, which she had memorized. I participated in this interview by answering the questions. At the end of the interview, she spoke to me in these words with a smile: "Today it was your turn". She seemed satisfied with my compliance to her request, and we continued to have a 'normal conversation, though the

experience appears to have prompted women in the group to decide to open up to me. After a few hours, a woman I already interviewed in the same group decided to show me the rest of the misoprostol she used. Another woman told me about her friends' experience who was subjected to sexual violence in her request for an abortion. I considered this incident of role reversal to be a test or exam that gave me the "merit" of accessing information that the participants had carefully kept for themselves until then. The most difficult requests to meet were those related to health concerns. Women were concerned about how to stop using provider-controlled contraceptives such as Implants. Some of them asked me about the risks they face when using emergency contraception frequently. Others were worried about the lack of menstrual period or heavy periods after using contraception. In these cases, I took care to contact some health workers I met during my fieldwork. Thus, after counselling, some of them could remove their contraceptive device free of charge as stipulated in the care policies. Without my involvement, some of them may have run the risk of paying money before the withdrawal. The others got their question answered after I checked with health workers (by calling them on their phone). Given these situations, I can say that the good relationship I had with health workers also improved the one I had with women because, beyond my research goals, women seemed to feel that I was 'useful' to them. As some of them used to say, "you saved me".

The relationship I had with health workers and certain NGO actors focused on my interest as a researcher because some took advantage of our relationship to ask me for favours. One day after an interview, a health worker told me that she had data that she was looking for an opportunity to disseminate some research she had done. I gave her the link to a conference that was taking place in Europe and some feedback on her abstract, which was accepted. After this conference, I also supported revising her research protocol so that she could apply for a scholarship for a master study in Europe. Her application was accepted, and after all these events, our relationship becomes fraternal.

### [Analytic approach](#)

Data analysis occurred gradually throughout the research process through careful reading of interviews and field notes, asking questions of the data, consulting the literature, identifying themes, manually coding sentences related to abortion experience and the way women and health workers define or perceived family planning its methods.

Both deductive and inductive strategies guided the thematic data analysis process. I coded my interviews data, including field notes with specific preconceived categories derived from my own research experience previous and my reading of the literature on family planning and abortion

(Adjamagbo and Koné 2013, Teixeira, Bajos, and Guillaume 2015), such as women's reproductive experience, affective trajectories, relationships with contraception and abortion, the decision-making processes about these methods, and their choices and motivation of contraceptive methods. Inductively established themes such as "the use of contraceptives for other purposes than family planning" emerged directly from the data when reading transcripts carefully. The themes identified during the analysis drew out biographical details of the women's lives while pointing out practices or events that dealt with their reproductive life. The events were related to each other by considering their chronology. This data summarized the stories of women.

Information gathered from research material (interviews, field notes, and observations) allowed me to summarize the women's stories based on their experience using contraceptives and abortion methods (Adjamagbo and Koné 2013). Women's life trajectory or events (social, love relationships, marriage, pregnancies, reproductive health experience, family, economic activities, etc.) allowed me to write their social and reproductive life experiences.

## Conclusion

In this chapter, I presented the methodological approach adopted to collect the data by describing the context and conditions of their collection and how I analysed them. Beyond the descriptive aspects, the chapter allowed me to reflect on the process of my ethnography and its ethical implications. The section has shown how access to research participants and the methodological choices impose a way of doing the fieldwork, which obliges the researcher to play roles and positions during fieldwork while showing how the researcher methodological choices and interaction with different category people in the field participate in the production of knowledge. In the next chapter, I summarise the findings of my ethnography and the unifying elements of the papers that form part of the PhD thesis.

## Chapter 5: Results

The results of my doctoral research are presented across two peer-reviewed journal articles and a peer-reviewed chapter in an edited volume, together addressing my overarching research questions. First, under what circumstances are contraceptives and misoprostol sold, circulated, and consumed? Second, how do women use contraceptives and misoprostol to manage their social, sexual, and reproductive lives? The order of the articles is based on the articulation of the research question presented in Chapter 1 and not on the year of publication of the articles.

The table below summarises the titles and aims of each Paper, and the empirical data they draw on. All the results presented in the three papers derive from ethnographic fieldwork conducted in Ouagadougou between March 2016 and February 2017, as set out in Chapter 3.

### Overview of articles

<b>Paper title</b>	<b>Aim</b>	<b>Empirical data</b>
Beyond 'family planning' – local realities on contraception and abortion in Ouagadougou, Burkina Faso	To explore the complexity of family planning within the context of women's lives and care seeking trajectories	Participant observation; In-depth interviews with 46 women and 14 healthcare workers
The domestication of misoprostol for abortion in Burkina Faso: interactions between caregivers, drug vendors, and women	To explore how the uses of misoprostol to induce abortion depend on processes of 'pharmaceutical diversion' and 'domestication'	Participant observation; In-depth interviews with 46 women and 22 healthcare workers, and five drug vendors
A pill in the lifeworld of women in Burkina Faso: Can Misoprostol reframe the meaning of abortion	To describe how the use of misoprostol to terminate pregnancy contributes to changing women's perception of the meaning of abortion	Participant observation; In-depth interviews with 16 women who have experienced abortion

### Paper I: Beyond 'Family Planning'—Local Realities on Contraception and Abortion in Ouagadougou, Burkina Faso. (2020)

Political commitment to family planning in Burkina Faso means that women have access to a range of contraceptive methods. "Family planning," particularly the use of hormonal and other "modern" contraceptives, has long been pushed as part of global health initiatives. Paper I investigates the complexity of the idea of "family planning" in the social context of Burkinabe women's lives and care-seeking trajectories.



Paper I explains how women's use of reproductive health commodities to prevent or terminate pregnancy is entwined with larger societal quandaries concerning marriage, sexuality, and gendered relationships.

Women's narratives, collected through in-depth interviews, show that their use of contraception demonstrates significant agency in the management of their reproductive and social life. They resort to contraceptive methods and abortion commodities to prevent or to terminate their pregnancy, and use modern contraceptives or methods described as natural or traditional in the public health discourse (Figure 3). At the same time, male partners frequently exercise power over women's contraceptive use, for example compelling their partners to take contraception. Furthermore, when women use 'modern' contraceptives, they often imbue them with functions other than their intended biological applications to gain weight to be attractive to men or stop menstrual flow so that they can undertake religious activities (fasting for Ramadan and performing pilgrimage). Paper I also argues that women's diverse uses of fertility-regulating commodities reveals the limitations of quantitative data and public health discourses that limits contraceptive use to family planning.



Figure 3: "African" pill used by women

## **Paper II- The Domestication of Misoprostol for Abortion in Burkina Faso: Interactions between Caregivers, Drug vendors, and Women (2022).**

As discussed in Chapter 1, misoprostol has been hailed as a revolution for maternal health globally because of its potential to reduce pregnancy-related mortality and morbidity and to provide relatively safe and discreet termination or pregnancy. Paper II shows that the growing use of misoprostol in Burkina Faso to induce abortion depends less on formal policies designed to regulate its use and more on women's 'informal' uses of this new reproductive health commodity.

Paper II argues that the use of misoprostol to induce abortion depends on processes of 'pharmaceutical diversion'- the process by which healthcare workers and pharmacists connect with broader networks to diffuse pharmaceutical products outside of their formal regulated circuits (Lovell 2006) and 'domestication' – how consumers create new uses for biomedical goods (Childerhose and MacDonald 2013).

Despite legislation aimed at restricting the use of misoprostol to terminate pregnancies, people can redirect its use for clandestine abortion. Drug sellers, health professionals, and sex workers are among the key intermediary players in the networks that allow women to access misoprostol for abortion. Women 'domesticate' misoprostol in various ways. The drug allows women to have a relatively safe abortion, albeit clandestinely; it also allows health care workers to conduct illegal abortions discreetly, or to support their acquaintance to access abortion.

While relatively safer than traditional clandestine forms of unsafe abortion, access to misoprostol is marked by pre-existing social and economic constraints, vulnerabilities and inequities. Misoprostol is thus a drug that illustrates that reproductive health commodities have a social life, and that their meaning and values are accumulated and transformed during interaction. Women with strong social networks may get misoprostol easily and at little or no cost, while other women not only struggle to get the drug but are sometimes victims of sexual abuse by male abortion providers in the process of trying to obtain it.

## **Paper III: A Pill in the Lifeworld of Women in Burkina Faso: Can Misoprostol Reframe the Meaning of Abortion? (2019)**

Paper III explores how the introduction of misoprostol changes not only access to, but also the very meaning of abortion. Drawing on the testimonies of 16 women who self-identified as having experienced abortions in the past, Paper III describes how the use of misoprostol contributes to modifying women's perception and experiences of induced abortion, and helps them to redefine abortion in terms that are morally acceptable to them individually and to their social networks, within a context where abortion is legally restricted and socially stigmatised. In contrast to surgical

techniques, which reduce women to patients and make them reliant on medical actors to terminate their pregnancy, misoprostol enables women to exercise agency in managing the process of inducing abortion. Furthermore, some women report that pregnancy termination with misoprostol is less painful and results in a post-abortion phase with less stress. When women take misoprostol after a delay in their menstrual cycle but without having confirmed that they are pregnant. They liken misoprostol to a contraceptive strategy, rather than to abortion that triggers strong condemnation. In conclusion, Paper III claims that the meaning of abortion varies depending on how people see and characterize their pregnancy experience. Misoprostol, as a reproductive commodity, has altered this process.

## Chapter 6: Discussion

The previous chapter summarized the finding of the three Papers that comprise the thesis. In this chapter, I discuss the unifying elements of the three Papers, discuss the significance of my findings and identify my contribution to public health approaches and to the feminist and critical scholarship on global reproductive health I reviewed in Chapter 2. I discuss what my findings reveal about the social life of contraceptives and misoprostol, before reflecting on how my focus on actors downstream of political decisions helps to challenge traditional public health concepts and discourses on family planning and abortion. Finally, I discuss how my ethnographic approach identified implication of technologies that statistics and other metrics cannot capture.

### The social life of reproductive health commodities

In this thesis, I have used the theoretical orientation of “social life of things” to analyze the use of reproductive health commodities in relation to the social circumstances in which various actors (women, drugs vendors, healthcare workers) interact and ascribe meaning to them or are influenced by the opportunities that they offer (Whyte, Van der Geest, and Hardon 2002, Desclaux and Egrot 2015).

By paying attention to the social life of reproductive health commodities, the thesis directs attention to why people's attitudes toward policies offering reproductive health services are not uniform and how their use of reproductive health commodities can give rise to unpredictable practices or unintended uses (Ginsburg 1995). My ethnographic research shows that reproductive health commodities are domesticated medical artefacts and have different significance for people who use their agency to obtain them and use them in the management of their reproductive lives. This theoretical orientation prompted me to explore how their substantive and material features allow them to fulfil several functions that influence the social life of people who access, use, and distribute them (Renfrew 2001).

This thesis is one of the first in-depth studies from Burkina Faso of how misoprostol is used within the context of women's social lives and at the intersection of formal and informal systems of reproductive health care. Paper II and Paper III show how misoprostol not only allows women to have a discrete illegal abortion, but also represents medical, economic, and social values for various actors, including women health workers and drug vendors. In this way, misoprostol takes on social life, in Appadurai (1988) sense. From a biomedical perspective on safe abortion, misoprostol's significance derives from its ability to terminate pregnancies effectively and relatively safely. However, the way misoprostol is perceived by my study participants shows that the status of a drug is not built solely on biomedical evidence. The articles by Dao and colleagues

(2009), Thieba, and colleagues (2013) on the use of misoprostol in the management of postpartum haemorrhages and incomplete abortions in Burkina Faso, have shown the therapeutic efficacy of misoprostol in authorized care. My thesis contributes new knowledge about how it is used in non-authorized care and its clandestine use for self-induced abortion.

This exchange of misoprostol increases the value (economic) of the drug for healthcare workers and drug vendor who often participate in its circulation. The social value of misoprostol is illustrated through the bonds of organic solidarity (gift and exchange between friends) that its use implies, as Paper II demonstrates. Misoprostol access and use can also help women to terminate a pregnancy that could cause them social problems. The way in which misoprostol works helps women to justify their termination, classifying it as not being an *actual* abortion because they use the drug to expel the foetus at the early stage of pregnancy (or without confirming a pregnancy). At the early a stage of the pregnancy women commonly consider the foetus a thing ('*bumbum*' in Mooré language) and not a person, as Ouedraogo and Juma (2020) found during their research in Burkina Faso.

My findings are also consistent with several anthropological works showing that technology plays a significant role in defining and interpreting reproductive experiences (Wynn and Trussell 2006, Callahan 1986). For example Gerber (2002) examines how pregnant women in France consider the small amount of what they see from an expulsion caused by misoprostol as not being a foetus. This way of defining or interpreting the termination of a pregnancy due to the effects of misoprostol is a relevant illustration of Callahan (1986) analysis on how technology can have moral implications by provoking new moral arguments about abortion. Furthermore, the findings of Paper II showing that women often use misoprostol as a contraceptive reveal the blurry boundary between preventing and terminating pregnancy.

Paper I shows that modern contraceptives bring medical, aesthetic, and religious benefits to women. Additionally, these contraceptives are significant for women because the commodities' characteristics produce effects beyond fertility control. This ties in with Renfrew (2001) analysis, which shows that the value of objects depends on their substantive and material features. For example, injectables and implants, which are hormonal contraceptives, influence the regulation of periods and the body's morphology. Therefore, some women use hormonal contraceptives to gain weight. The use of modern contraceptives to achieve objectives other than "family planning" has also been identified in other studies. For example, Boydell (2010) shows how women in England used the contraceptive pill to conceal or avoid blood flow from their period that required changing planned activities, which forced them to take leave from work or gave mood swings that

made it challenging to deal with. Hull and Hull (2001) describe how women in Indonesia use the contraceptive pill to stop their menstruation to be able to perform religious rituals, similarly, to what I observed in Burkina Faso. These findings demonstrate how women convert a medical commodity into an aesthetic one or use it to facilitate religious rites. These diverted uses of contraceptives occur in a context where the quest for individualization of the body (control of the body in its forms, appearances, and performances) transforms it into an endless construction site in which contraceptives play a role.

Thus, women's agency, pragmatism, and domestication of these reproductive comforts enable them to dismantle set categories about their medical efficacy, demonstrating that the logic behind their usage is not linear. This situation invites for a critical examination of public health concepts pertaining to abortion and family planning.

### Discrepancies between public health discourses and women's pragmatic uses of reproductive health commodities

In Burkina Faso, global health policies influence reproductive health governance via development programs that monitor and assess family planning using demographic concepts such as modern contraceptive prevalence and unmet contraceptive need, which are used to assess individual contraceptive use and to evaluate the results of different contraceptive programs across countries or between regions. Health authorities and public health professionals sometimes portray abortion-related pregnancies as "unplanned" pregnancies that occur because of women's "unmet need" or failure to utilize contraceptive measures. Given Burkina Faso's restrictive abortion law, policymakers employ a medicalized discourse that portrays abortion as reflecting "unmet need" for contraceptive methods and emphasizing the importance of "creating demand" for family planning (Storeng and Ouattara 2014). For instance, monitoring and assessing diverse programs globally using these indicators is a component of what Olivier de Sardan, Diarra, and Moha (2017) refers to as standardized global public health models. From this vantage point, reproductive health achieved via family planning remains unclear, since programs are often monitored and evaluated using demographic notions that were in vogue during the period of population control measures (Kuumba 1999, Bhatia et al. 2020, Suh 2021a). Furthermore, these standardized global policies have been criticized for treating women from the global South as monolithic subjects with identical needs and desires, powerless, exploited, and as victims of patriarchy, and assuming that access to reproductive health commodities could be sufficient to empower them or satisfy their desires (Mohanty 1988). Following Mohanty (1988), the findings of this thesis support this criticism and show that women are not a homogenous group and that they can exhibit a variety of needs and aspirations when it comes to the use of reproductive health commodities.

Thus, by focusing on the daily lives of actors who are not directly involved in political decision-making, this thesis elucidates the inherent tensions and gaps between standardized global public health models (Olivier de Sardan, Diarra, and Moha 2017), reproductive governance (Morgan and Roberts 2012) and the pragmatism of women in controlling their fertility and social life (Lock, Kaufert, and Harwood 1998), privileging women's own accounts of fertility control. By demonstrating that women use modern contraceptives for non-family planning purposes and that health professionals comply to their demands and do not record them, the thesis casts doubt on the accuracy of statistics on contraceptive prevalence as a proxy for the efficacy of family planning efforts. Furthermore, my findings allow me to question the concept of women's unmet needs for contraception, since women take contraceptives for purposes other than family planning. Additionally, women may opt out of modern contraceptive techniques encouraged by health programs in favour of options that are more appropriate for their social and individual circumstances, as Jansen (2020) similarly found in Madagascar. In this context, not using modern contraceptive methods does not mean that women do not resort to other methods and strategies to prevent pregnancy. Contraception is ineffective for some kinds of women because they do not follow the logic of childbearing, while other women turn to abortion as a conscious decision to prevent future pregnancy, as explained across my PhD publications.

Building on Mohanty (1988) critique of treating women as a homogeneous category, I propose that at least four categories can be identified in my ethnographic material to describe women's varied relationships to family planning programs: 1) women who struggle to access or who cannot access contraceptive methods due to the reticence of their male partner; 2) those who do not see the need to use contraceptive methods; 3) those who choose abortion; and 4) those who use contraceptive methods to meet other needs. However, there is a need to acknowledge that these categories are not mutually exclusive because women can fit into one or another of these categories at different points of their life course. In this regard, my findings support those researchers who have criticized the reductionist nature of the concept of unmet contraception, claiming that it does not accurately represent people's lived experiences with family planning programs (Murphy, 2012). As Foley (2007) points out in her ethnography from Senegal, including all women who do not use modern contraception in the statistics on unmet need for contraception would result in an overestimation of the problem. She illustrates how high fertility could be the most natural reproductive strategy for many women who are engaged in marital partnerships to keep their relationships.

My findings support De Sardan's and colleagues' (2017) work on the limits of global health policies and their travelling models, which always encounter differences between what is intended and

what occurs on the ground. When reproductive governance is centred on models, data, and technology, it is unsurprising that policies encounter roadblocks due to the logic of various players. For example, my study shows that, like women, healthcare workers do not unreservedly adhere to the established regulations for the provision of care. De Sardan refers to this as "practical norms," which are standards that eschew rules, procedures, and controlling conduct. My findings resonate with Suh's (2020) research in Senegal, which demonstrates that health professionals sometimes exhibit selective attitudes in response to established work restrictions. The discrepancy between provided reproductive health services and women's and healthcare workers' attitudes, reminds us that women's attitudes toward reproductive health policies do not exist in isolation from other aspects of their lives, such as gender relationships, economic and social circumstances (Mumtaz and Salway, 2009), their trust in commodities, or the opportunities they perceive in commodities. Furthermore, the discrepancy between global reproductive health policies and people's daily practices and the limits of demographic notions demonstrate that there are many reproductive experiences that metrics are unable to accurately capture (Suh 2020). While statistics can tell us how many women have used a certain form of contraception (Maïga et al. 2015, O'Regan and Thompson 2017, Wulifan et al. 2017), they cannot tell us how many use it for other reasons than family planning or tell us how many use misoprostol as an emergency form of contraception. According to statistics, all sexually active women of childbearing age who do not use contraception are in unmet need. Obviously, this is not always the case as confirmed by Paper I. In Burkina Faso, the literature on misoprostol, which continues to be dominated by public health research (Kiemtoré et al. 2017, Kiemtoré et al. 2016, Dao et al. 2009, Thieba et al. 2012), fails to reflect the social lives and ramifications of this reproductive health commodity in the health system.

### **Reproductive health commodities and their impact in women's lives**

Reproductive governance around contraception and misoprostol often favours the establishment of initiatives that use metrics. By placing a premium on the creation and use of statistics, this governance overlooks a set of issues that cannot always be converted into figures but are still "true". Therefore current reproductive health policies that emphasize the use of technologies and numbers have come under criticism from critical femininity scholars. For some feminist researchers, the transition from population control to reproductive rights was purely rhetorical (Hodgson and Watkins 1997, Bhatia et al. 2020) because the questions of rights and autonomy are more present in discourse than in practices. The tendency of neglecting the implication of reproductive health commodities in women's life may lead one to conclude that the focus on numbers and the expected medical effect of technologies might become a "problem" rather than



a “solution” if the circumstances under which they are available, accessible, and used remain unspoken in global discourses.

Thus, by giving a voice to women, men, and drug sellers, this ethnography contributes by documenting how people relate to the use of modern contraceptives and misoprostol in Burkina Faso. The reproductive experiences of the women portrayed in my three Papers demonstrate their ambivalent connection with these two reproductive commodities. On the one hand, they may help women manage their emotional and reproductive lives, but on the other hand, subject women to male dominance and gender-based violence. This ethnography agrees with researchers who have taken a critical look at reproductive health policies and the technologies they promote, without calling into doubt the benefits of these technologies to the advancement of women's reproductive and social life (Suh 2021b, Brunson 2020).

My thesis demonstrates that the focus on women's contraceptive techniques and the legal framework for misoprostol access in Burkina Faso contributes to the perpetuation of forms of violence against women and violates their sexual and reproductive health rights. Legal restriction on abortion, and on the use of misoprostol for abortion, does not prevent illegal abortions; rather, it serves to disadvantage women who are unable to bypass the law due to their poverty. This poverty is not only material; it also refers to women's lack of awareness about where and how to get relatively safe illegal abortion, the frailty of their social networks, and their financial misery. Additionally, Burkina Faso's reproductive governance, which promotes more the use of long-acting contraceptives than others methods, casts doubt on the concepts of autonomy, free choice, and rights because the provision of services motivates or constrains women to use specific methods by limiting their options. Additionally, the concept of autonomy is constrained by the process of medicalization, in which women become reliant on health practitioners to get contraceptive methods such as intrauterine devices (IUDs) or implants (Hardon and Moyer 2014). The emphasis on these contraceptive devices often exposes women to coercive behaviours, since some of them must deal with healthcare workers who, for example, refuse to remove their implants (Senderowicz, 2019). Coercion over family planning use can lead to men refusing to allow their partner to use a contraceptive method, as evidenced by several studies in Burkina Faso that showed that men frequently condemn the use of modern contraception to control their female partners' sexuality (Ouattara, Bationo, and Gruénais 2009, Désalliers 2009). While my ethnography conforms to previous literature, it also highlights another dimension of coercion within couples which is absent from the literature on contraceptive use in Burkina Faso. In this perspective, this thesis showed how men oblige their partners to use a modern method of contraception, as described in Paper I.

Critical scholars on global reproductive health policies highlight that in neoliberal development and poverty reduction frameworks, individual capacity building is emphasized, which may hide structural and power dynamics and disparities. (Wilson 2015; Mohanty 1988; Bhatia et al. 2020, Kuumba 1999; Bendix and Schultz 2018). As my thesis shows, the reproductive choices and the use of reproductive health commodities of women in Burkina Faso are intertwined in a complex social “reality” where economy, religion, and genders relationships occupy a significant role. Women are exposed to abuse and sexual assault because of unequal access to commodities such as misoprostol, which, far from assisting them to achieve safe abortions, as documented in paper II. This throws into question the meaning of “safe abortion”, which cannot be attained just via the availability or circulation of reproductive health technology.

## Chapter 7: Conclusion

The use of reproductive commodities occupies an essential place in women's social and reproductive lives that is firmly structured by gender relations and reproductive health governance, which can facilitate or limit their access and use. In my thesis, I have relied on the notions of agency and pragmatism to analyse women's unique experiences and contextualize their uses of their reproductive commodities, revealing how abortion and family planning methods intervene as a continuum in their lives. The use of the notion of the social life of things prompted me to reflect on the multi-dimensional function (medical, social, economic) of reproductive health commodities, and how they are interpreted and used. It also allowed me to move analytically beyond the biomedical function of these commodities to explore their social use. My thesis shows that contraceptives and misoprostol are not neutral commodities. They circulate between individuals and in different contexts and obtain different statuses while influencing the social experience of their users. Moreover, the diverted use of these commodities revealed by my ethnographic research challenges the frequent top-down orientation of reproductive governance.

The study's wider impact is to challenge standard public health understandings of reproductive health commodities. In contrast to demographic studies that emphasize standardized statistics to inform programmatic practice and policies, the thesis provides insight into the context of women's reproductive lives, in which motivations to use different reproductive health commodities reflect social and romantic relationships, socio-economic circumstances and broader social objectives. The thick description provided across the three papers identifies important gaps in access to care and challenges the depiction of misoprostol as a "revolution" that puts safe abortion into the hands of women. On the contrary, I show that women seeking misoprostol often face discrimination and abuse in trying to access this drug, and that it does not eliminate the risk of being held responsible for breaking the law, nor the risk of needing costly post-abortion care should something go wrong.

This thesis enabled a deeper understanding of various practices and perspectives related to the use of reproductive health commodities, which evolve according to unpredictable situations that cannot always be quantified. Thus, as a consequence, policy actors become "powerless" to stop the new directions or meanings they take once they are in the hands of the people.

The research has some limitations. First, in focusing on women's experiences, men's attitudes towards and experiences of navigating access to reproductive health commodities has not been foregrounded. My understanding of men's perspectives derives primarily from women's accounts rather than directly. Another limitation relates to the absence of policy makers' perspectives on

abortion, family planning and the circulation of reproductive health commodities. An ethnography on political actors' perspectives in Burkina Faso could make it possible to understand the emergence, development, and implementation of programs and policies relating to reproductive health commodities. The ethnography could document how the actors and their policies position themselves with the ambivalence that family planning and abortion raise.

Burkina Faso's government institutionalized free family planning and neonatal and maternity care for pregnant women and children aged 0 to 5 years old in 2016, during my fieldwork. It will be fascinating to watch how misoprostol and contraception are utilized in this context of free care. Are we going to see an abusive use of contraceptive methods particularly because women desire them for purposes other than biomedical? What will be the status of misoprostol in this policy of free care, given the stigma associated with abortion?

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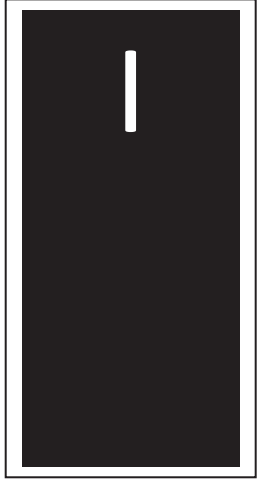
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# Papers







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 Kotni 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 contraceptive<sup>1</sup> 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 2008<sup>2</sup> (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

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<sup>1</sup> 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.

<sup>2</sup> 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 partnerships 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 necessary 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 Jadelle<sup>3</sup> 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).

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<sup>3</sup> 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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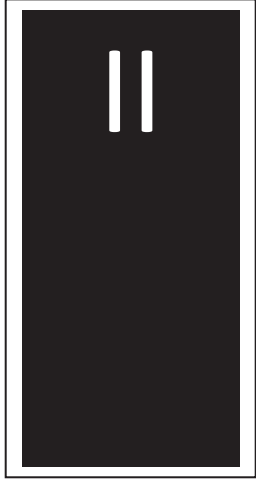
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# Chapter 4

## The Domestication of Misoprostol for Abortion in Burkina Faso: Interactions Between Caregivers, Drug Vendors and Women



Seydou Drabo

### Introduction

Misoprostol has been hailed as a revolution for maternal health globally because of its potential to reduce mortality and morbidity from post-partum haemorrhage and unsafe abortion (Potts, 2006), providing relatively safe and discreet termination of pregnancy (Winikoff & Sheldon, 2012). Since 2005, the World Health Organization (WHO) has recognized misoprostol as a lifesaving drug and recommended that it be included on the list of essential medicines, although only 'where permitted under national law and culturally acceptable' (World Health Organization, 2006). Advocates of safe abortion services, however, fought for its inclusion in the treatment of post-partum haemorrhage in countries with restrictive abortion laws, with the expectation that once it is in the health system, women will be able to access it and thereby avoid harmful abortion procedures (Fernandez et al., 2009; Hofmeyr, 2012).

A recent report examining the safety of abortion globally suggests that clandestine abortion in legally restrictive settings is becoming relatively safer as misoprostol replaces harmful methods (Singh et al., 2018). However, we know little about how women actually use misoprostol to induce abortion. This chapter addresses this knowledge gap by examining how misoprostol is acquired and used by women, drug vendors and healthcare workers to manage unwanted pregnancy in Ouagadougou, the capital of Burkina Faso in West Africa. Previous studies have shown that privileged individuals are able to circumvent Burkina Faso's restrictive abortion law by resorting to private clinics that offer clandestine abortions (Storeng & Ouattara, 2014). Misoprostol is marketed in pharmacies and drug stores, enabling women to avoid clinics altogether and access the drug in secrecy (Moland et al.,

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57

2018). This chapter shows how the uses of misoprostol to induce abortion depend less on the formal policies designed to regulate its use than on women's 'informal' use of the drug.

I analyse how misoprostol circulates outside Ouagadougou's formal healthcare system as a form of 'pharmaceutical diversion'. Ann Lovell defines pharmaceutical diversion as a process that connects formal healthcare providers and pharmacists with networks of individuals who 'diffuse the product and knowledge about it' beyond the clinic (Lovell, 2006, p.156). Thus, the chapter focuses on the micro-level of the everyday practices of individuals who seek to acquire, circulate and use diverted pharmaceuticals outside their formal regulated circuits, uses and applications. Similarly, women's uses of misoprostol can be conceptualized as what Childerhose and MacDonald (2013) call 'domestication' – how consumers create new uses for biomedical goods, including drugs and devices that were never intended by manufacturers or regulators and are not overseen by professionals. The notion of domestication has particular relevance for how consumers bring biomedical goods into their homes for reasons of privacy and personal agency, in the sense of the ability to influence one's life by acting independently (Mortimer & Shanahan, 2003). This research also reveals the critical role of intermediaries in the process of pharmaceutical diversion and domestication, which often creates inequalities in access to misoprostol, complicating the narrative of misoprostol as a therapeutic revolution in the prevention of unsafe abortion. This study reminds us that access to misoprostol varies across settings, and while relatively safer than clandestine forms of unsafe abortion, may also be marked by pre-existing social and economic constraints, vulnerabilities and inequities. Therefore, misoprostol is a drug that illustrates and confirms that drugs have a social life. The notion that medicines have a social life is well established in medical anthropology, referring to the fact that medicines are more than their chemical properties and effects in the body; the way they are produced, tested, circulated, used and made meaningful is always shaped by their social and cultural contexts (Van der Geest & Whyte, 1989; Whyte et al., 2002).

## **The Social, Legal and Policy Context of Misoprostol in Ouagadougou, Burkina Faso**

In 2008, it was estimated that one-third of all pregnancies among women aged 15–49 years in Burkina Faso were unintended. One-third of these unintended pregnancies ended in abortions (Bankole et al., 2014). The incidence of abortion for women of reproductive age in Burkina Faso was estimated at 25/1000 in 2012 (Bankole et al., 2014). That rate is comparable to the level observed in 2008 for the West Africa sub-region (28 per 1000 women aged 15–44 years) (ibid).

In Burkina Faso, induced abortion is socially stigmatized (Drabo, 2013) and legally restricted to cases of rape, incest, foetal malformation or endangerment to



the woman's life. According to Burkina Faso's penal code, inducing abortion is punishable by up to 5 years of imprisonment and a fine and, in the case of a woman's death, up to 12 years for a person helping a woman to abort (La voix du Juriste, 2013). Due to the legal restrictions, most women seeking abortion resort to unsafe means to terminate their pregnancy, at significant risk to their health. It is estimated that half of women who induce their abortions alone experience complications, compared with about 2 in 10 women who go to healthcare providers performing illegal abortion (Bankole et al., 2014). The safety of abortion in this context depends on women's social and economic status and the differences between rural and urban areas in terms of cost, accessibility and safety (Bankole et al., 2014). Overall, safe abortion<sup>1</sup> methods are relatively inaccessible throughout Burkina Faso, especially for rural women (ibid). Ninety-seven percent of abortions performed in rural areas are unsafe and poor women in rural areas typically experience the most significant health risks. Seven in 10 women living in rural areas end their pregnancies themselves or use traditional practitioners who are perceived to be discreet.

The government response to unsafe abortion has been limited to implementing a Post-Abortion Care (PAC) policy to treat complications (Ouattara & Storeng, 2014; Storeng & Ouattara, 2014). A range of technological options, including emergency contraception, vacuum aspiration and medical abortion, are used to treat incomplete abortion and prevent unwanted pregnancy in Burkina Faso. Manual vacuum aspiration (MVA) and misoprostol were introduced in the care policy in 1998 and 2014, respectively. In urban areas, private or clinic-based doctors or other healthcare providers, such as midwives and auxiliary midwives, often carry out abortions illegally. Though more costly than those offered by traditional providers, these procedures, including MVA or misoprostol, are considered relatively safe compared to other methods such as the insertion of sticks or sharp objects into the vagina, the consumption or vaginal application of kola, abortifacients like herbal tea, potions and high doses of drugs like anti-malarials, or bleach (Bankole et al., 2014).

## Field Site and Methods

My fieldwork focused on Ouagadougou, a city of 2.7 million (CWF, 2018), which is also Burkina Faso's capital and its administrative and economic centre. In Ouagadougou, women can access abortion care in the public sector only in the circumstances stipulated by law (incest, rape, foetal malformation, health of the mother). However, PAC services are offered in secondary and tertiary healthcare facilities, some primary healthcare facilities in the public sector and in private-care

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<sup>1</sup>WHO classifies abortion as safe if it takes place using a safe method and is done by an appropriately trained provider. Less-safe abortions include those done by a trained provider but using an outdated method, and self-induced abortions using a relatively safe method (e.g., misoprostol); least-safe abortions are those done by an untrained person (a provider or the woman herself) using a dangerous method. Both 'less' and 'least' safe abortions are considered unsafe.

facilities (Bodart et al., 2001). Misoprostol can be purchased to treat incomplete abortion and manage post-partum haemorrhage in the city's hundreds of pharmacies (Ministry of Health of Burkina Faso, 2014). Misoprostol also circulates outside the official framework in Ouagadougou, and it is often referred to locally as the 'abortion drug'.

Building on previous experience studying maternal mortality and PAC in Burkina Faso's health sector (Drabo, 2013; Storeng et al., 2013), two periods of ethnographic fieldwork were undertaken between 2015 and 2017 in the city of Ouagadougou. The fieldwork was conducted in the framework of my PhD research focused on the use of contraceptives and abortion drugs. During the first period (October to December 2015), I focused on healthcare professionals' use of misoprostol in nine health facilities, including two University Hospital Centres, four primary healthcare centres, one private medical centre and two private primary care centres. I conducted interviews or had informal discussions with 22 healthcare workers, including gynaecologists, midwives and auxiliary midwives working in maternity care units.

In the second period of fieldwork (March 2016 and February 2017), I focused on women's perspectives and experiences in seeking out an abortion, including medical abortion using misoprostol. I conducted participant observation in streets and market places, interacting regularly with various women and drug vendors. I observed pubs and the streets of Kwame Nkrumah, a main thoroughfare with many hotels, restaurants, pubs frequented by men and women who work as waitresses or sex workers, often referred to collectively as '*les filles de nuits*' (girls of the night). These observations allowed me to start conversations around the issue of abortion and to negotiate in-depth interviews with some of the women, who, because of their work, are at risk of unintended pregnancy, abortion and their consequences (Drabo, 2019; Weldegebreal et al., 2015).

To understand the context of drug sales and the interactions between drug sellers and consumers, I conducted observations and informal discussions with street drug vendors by spending time with them in their market place. During events like movie festivals (FESPACO), the public authorities officially establish a merchant street where traders come to expose their products. Drug vendors participate in these activities by showing and selling their products for 1 week. I stayed in the store of one of the drug vendors who was selling non-western contraceptive methods and other drugs purchased by women. The long hours spent waiting there (3–6 h) gave me the opportunity to have discussions with both the drug vendor and some of his clients (see also Drabo, 2019).

In addition to participant observation, I conducted in-depth interviews with 46 women (in the context of my broader PhD research project) about their reproductive trajectories, perceptions and practices of contraceptive methods and abortion drugs and the decision-making processes and networks involved in the procurement of misoprostol. Healthcare workers assisted me in identifying women who had sought family planning and PAC and were willing to participate. I used my social networks to identify other participants from the general population. This strategy consisted of asking women who were closer to me (neighbours, former classmates and friends) and who agreed to participate in the study. Subsequently, I relied on these women to access other women (friends of friends) who were also willing to participate in the

study. Of the 46 women I interviewed, 16 reported that they had undergone induced abortions in the past. These 16 interviews form the basis of the analysis in this paper. Among this group, nine were single women, four were cohabiting with a man, two were married and one was widowed. Seven of these women were working as servers in a pub, three were students, three were petty traders, one was a maid, one a housewife and one a public servant. Five of the women in this group had had more than one abortion. Together, these sixteen women had 23 abortions between 2010 and 2017. Ten of them reported using misoprostol to terminate one or more pregnancy. The other methods women used to terminate their pregnancy included MVA, potassium permanganate, Chinese pills and a recipe made with a plant (see also Drabo, 2019).

### *Data Analysis and Ethical Issues*

I conducted interviews in French, Mooré or Dioula depending on participants' preferences (I speak these three languages fluently). Most interviews were tape-recorded (with the exception of three people who were more comfortable with note-taking) and transcribed verbatim. Interviews lasted between 20 min and 1 h and 30 min. A research assistant transcribed the interviews and those recorded in Mooré or Dioula were translated into French. I did the final editing, checking all the transcripts to ensure accurate transcription and translation. I identified recurrent themes from interview transcripts and observational notes and analysed the texts based on the research question, which was focused on the use of misoprostol.

Quotes used in this chapter to illustrate the findings have been translated from French to English. I obtained ethical approval for the study from the Ethical Committee of Burkina Faso and the Norwegian Centre for Research Data. Informed consent forms were read aloud to the research participants, who provided verbal consent; verbal consent was also the most suitable because of the topic's sensitivity for healthcare providers, drug vendors and women. In addition to receiving informed consent, I assured my participants of my good intentions. For example, I made women understand 'my goal is not to judge but to understand'. This attitude allowed me to establish a climate of trust with participants to make them feel comfortable talking about their reproductive life experiences. I told all participants they could withdraw from the study at any time or choose not to participate in the study. The names of participants cited in the quotes are pseudonyms (see also Drabo, 2019).

### **How Health Providers and Drug Vendors Circumvent the Regulation of Misoprostol**

There are mechanisms in place in health facilities to prevent misoprostol from being used outside the legal framework for its uses. Interviews with healthcare providers indicate only gynaecologists are authorized to prescribe misoprostol. In the medical

centre and hospital, midwives are supposed to use it only under the supervision of a gynaecologist in the treatment of incomplete abortion and in the management of post-partum haemorrhage. In primary healthcare centres, only specially trained midwives are allowed to prescribe misoprostol without the advice of a doctor, and only for PAC. In practice, however, auxiliary midwives often prescribe and use it under the guidance of a midwife. Thus, gynaecologists, midwives and auxiliary midwives are involved in the management of misoprostol depending on the circumstances of care delivery. Furthermore, pharmacists and drug vendors explained that they are required by the Ministry of Health to write down the name of the health facility purchasing the drug, the date and the quantity of the product being purchased, as well as the name and the telephone number of the prescriber and the buyer. These restrictions are intended to avoid misoprostol being re-directed for induced abortion.

In addition to official regulations, health workers involved in the management of the drug in PAC take extra precautions to prevent patients from accessing misoprostol and using it to induce abortion. For example, some healthcare providers confiscate the remaining misoprostol tablets after PAC. A midwife in a district hospital explained: 'We tell them, for example, after prescribing that we cannot leave them with the rest of the product because they can be used to cause an abortion'. Despite regulations that aim to restrict the use of misoprostol to induce abortion, social and institutional factors enable its availability in the health system and individuals' access to it. First, misoprostol has been on the list of essential medicines for clinical use since 2014. Second, there are international and national NGOs working within the field of reproductive health who make misoprostol available in their private clinics and in some public health facilities claiming that they need it for PAC. Task shifting in care delivery allows midwives or auxiliary midwives to perform some of the therapeutic acts that are, on paper, restricted to gynaecologists. As a consequence, most of the healthcare providers working in maternity care units are able to acquire misoprostol and may use it to induce abortions. As a midwife working at the hospital explained: 'We used it for PAC, but there are people who use it to do abortions too. It happens, we have colleagues who do it and I will not give a name'.

In pubs, I observed that some sex workers and servers act as intermediaries between health workers providing abortion services clandestinely and women seeking abortion. Such links are sometimes established during sex workers' health visits and are mutually beneficial in providing sex workers with access to abortions and health workers' access to more clients in need of abortion services. For example, during one of my visits to a pub in Ouagadougou, I met Severine, a 20-year-old woman, who worked as server in the pub and also as a sex worker on the side. Severine told me that a male friend of hers who is a nurse gave her misoprostol tablets for free when she had an unwanted pregnancy and encouraged her to bring other girls who would need abortions to him.

The permissiveness of the drug distribution system in Burkina Faso, which allows individuals to access drugs without showing a prescription, generates conditions that permit illegal abortion (Ouedraogo, 2015). Like many other drugs in low-resource settings, misoprostol circulates as a commodity that can be sold and

purchased informally (Van der Geest & Whyte, 1989). Drug vendors play an important role in the illicit distribution of misoprostol, for example, by circumventing the rule to report information about the prescriber and the buyer of misoprostol. A drug vendor in a private pharmacy stated that he sometimes registers fake information in the drug sales record:

Often it is necessary to have a little imagination: you need the name of a recognized district hospital, it is very easy to write in the notebook. You put a doctor's name that we will never be checked and you write the product and the name of a fake buyer with wrong mobile number and the product is sold.

The same drug vendor explained that circumventing regulations is relatively straightforward; in 21 years of service, he has never been visited by an inspector. Social ties between drug vendors in pharmacies and healthcare workers can also facilitate women's access to misoprostol without a prescription. For example, one healthcare provider who admitted that he offers abortion services at his house explained how he procures misoprostol: 'As I am a health professional, I go with prescriptions to buy. I also know a lot of pharmacists who help me sometimes'.

These examples show the critical importance of intermediaries (health workers, drug sellers, sex workers, friends, etc.) in misoprostol access, though not all women depend on intermediaries to access misoprostol. Some women access misoprostol directly by going to a pharmacy; however, this requires tact and a certain ability to negotiate directly with drug vendors, as well as strong social networks or what Ouedraogo terms an 'abortion managing group' (Ouedraogo, 2015): all the individuals mobilized and involved in the abortion process (seeking out information, individuals, places or products that can assist in providing moral and financial support). In Ouagadougou, drug vendors in pharmacies, health workers and sex workers are among the actors involved in the networks that enable women to access misoprostol. These networks are often characterized by interactions that disappear once misoprostol is accessed. Later on, people involved in the process can contact each other again if the need for an abortion is expressed.

By ignoring the official requirement for a prescription and selling it off-label, drug vendors and health workers can be said to domesticate misoprostol. This domestication involves the diversion of misoprostol for illegal abortion, contrary to the official status assigned to it by Burkina Faso's health policies, and its sale as a commodity that has a negotiable price. These practices are encouraged by women's demands for clandestine abortions and give power to drug vendors and health workers, who can decide who can access the drug according to their rules and logics.

## **Intermediaries' Motivations**

Some health workers helping a woman to get an abortion take the position that doing so is a matter of the woman's right to health, since doing so can help her avoid the serious social and health consequences of an unwanted pregnancy, whether the

consequences of an unsafe abortion or the abandonment of children at birth. For example, one male midwife, who performs abortion illegally, said:

We have to help. They are women who come to give birth, they tell you vis-à-vis that the guy refused paternity. Sometimes they do not even know the person who is responsible for their pregnancy since they have dealt with two or three people. Some of them will tell you that they were raped. I tell myself that these people need help. There are also some other women who are ashamed because they have a little child. When all these women do not want pregnancy they take odd products to abort and then after they will face many complications. Those who decide to keep the pregnancy will give birth and throw away the baby.

Despite having declared their attitude to help people, individuals who sell misoprostol or practice abortion will do so following some conditions. For example, a drug vendor explained that he and his colleagues prefer requests from women who explain verbally that they need misoprostol, rather than someone who simply holds a piece of paper on which the name of the product is mentioned. In the latter case, drug vendors feel that they should not sell the product because of safety concerns: ‘you will see some people who arrive with just a simple piece of paper where it is written misoprostol. You can feel he does not even know what kind of product he is buying. If you give it to them, they may misuse it. So, to avoid problems we refuse to sell’. As for health workers who practice abortion, like the one I met, he helps only people referred to him through his social network; the ‘client’ has to come through someone he already knows, otherwise she is rejected.

Although misoprostol circulates beyond the clinic and the control of health workers, accessing it is thus not a given and requires negotiation. While health workers and drug vendors may be motivated to provide misoprostol for women on altruistic grounds, others judge the women’s need and ability to pay before setting a price or other terms of exchange. In short, buying misoprostol tablets is not just an economic transaction but also a complex process of networks and negotiation, which often involves vendors exerting power over the terms of access to the product.

## **Pharmaceutical Diversion of Misoprostol by Women**

Pharmaceutical (drug) diversion refers to the transfer of any legally prescribed **controlled substance** from the individual for whom it was prescribed to another person for any illicit use (Berge et al., 2012; Lovell, 2006). By using this notion, I refer to the way misoprostol, which is meant to be used for official indications such as PAC and the treatment of post-partum haemorrhage, is rather used for acts such as illegal abortions. Through the channel of friends and relatives, drug vendors and healthcare workers, women are able to access misoprostol to induce abortion. Despite the fact that it allows for self-induced abortion, the involvement of abortion providers seems important because they appear as ‘skilled’ players regarding the use of the drug. Moreover, the involvement of abortion providers in some cases has changed women’s access to illegal-induced abortion because it allows abortion providers to perform abortion discreetly (Drabo, 2019). As 23-year-old Awa explained:

My boyfriend contacted a doctor who gave us an appointment in front of a guest house. My boyfriend paid for the room and then waited outside. I went inside with the doctor who put some white pill inside me...After that I did not see him again. When I arrived home, I started bleeding a bit and it came out.

This example shows how misoprostol enables clandestine abortion providers to work discreetly, by removing the procedure from the healthcare setting where providers may risk prosecution if complications occur. Thus, both women and abortion providers benefit from the discretion misoprostol allows.

In addition to meeting the need for discretion, misoprostol also changes the cost of illegal abortion services. Women report that abortion with misoprostol was relatively affordable, around 8000 XOF (1 USD approximately equal 580 XOF), compared to abortion induced illegally by MVA, which can cost around 25,000 XOF. Furthermore, the price of misoprostol varies depending on how the product is accessed. It is relatively cheaper when women procure it to have a self-induced abortion than when they pass through a health worker. In the latter case, it is the price of abortion that is fixed and not that of the drug. As one informant told me, 'The price of abortion varies between 25,000 XOF to 200,000 XOF. Last time I was dealing with a former minister. I asked him to pay 200,000 XOF. In addition, with the population it varies from 25,000 XOF to 100,000 XOF'.

The variation of the price of an abortion, which is fixed by the abortion provider based on individual financial resources, suggests that people getting involved in illegal activities like abortion (by asking for the support of abortion providers) could render them susceptible to extortion. Accounts of individuals involved in the provision of abortion services show that although some abortion providers claim to 'help' women, abortion services always come at a price. Misoprostol establishes what Fiske has called an 'instrumental relationship' (Fiske, 1992) between drug vendors, healthcare providers and women (with their supportive person), meaning a relationship characterized by mercantile interest between people involved in a social interaction. This gives rise to negotiation between those who need and those who distribute misoprostol in which the price of the product is adjusted according to the characteristics of the purchaser. For example, the price may be lower or easily negotiated if the purchaser knows the provider or is introduced to them through a friend. Some women I spoke with accessed misoprostol without paying anything because their acquaintances gave them the drug for free, such as 35-year-old Diane, whose partner of 17 years is the father of her two children. After she announced her third pregnancy, her partner asked her to have an abortion and threatened to leave her if she kept the pregnancy. Diane decided to contact one of her friends, a medical doctor, to get misoprostol, who gave it to her free of charge. As she explained:

When I had my problem, I got the product for free. A friend helped me to get it from another friend. He did not buy it either because they are both health professionals and they mutually support each other. The other could not refuse because he knows that one day he may also need help (not only abortion) from my friend.

In addition to receiving misoprostol free of charge from friends in the medical system, women described how they obtained misoprostol from female friends or

relatives who had used it to self-induce abortion. These female friends or relatives gave the remaining pills from the packet they purchased as a gift. One woman confided that though she never had an abortion, her cousin gave her some misoprostol tablets in case she would need it one day. She interrupted the interview to go get the tablets and showed me a blister pack with six tablets missing.

As a gift, misoprostol reinforces the bonds of solidarity, friendship and kinship between women (Gregory, 1982), and means that one woman's abortion can allow that of another woman. Such informal exchanges highlight the agency of women and their role in 'domesticating' misoprostol (that is, how they create a use for the drug that was not intended by regulators) and disrupting the supply chain of misoprostol ordinarily controlled by healthcare workers and drug vendors. This concept of domestication (Childerhose & MacDonald, 2013) emphasizes agency and resourcefulness in the adaptation of technology for one's own ends. However, this adaptation ability is not the case for all women who seek to access misoprostol through informal networks.

## **When the Diversion of Misoprostol Reproduces Social Inequities**

Although women with strong social networks, including friends and relatives who know healthcare workers or drug sellers, may access misoprostol relatively easily and at little or no cost, other women struggle to obtain the drug. They struggle to find information about where to buy it and the right way to induce abortion. These difficulties in accessing misoprostol push some women to turn to private clinics recognized to provide abortion services at a higher price than they can afford, as highlighted in Francine's story.

Francine, a 23-year-old domestic maid, became pregnant with a 16-year-old boy and decided to terminate the pregnancy. After a week of unsuccessful research, she was finally able to find, through a friend, a private clinic that belongs to an NGO offering abortion services discreetly. Once in the clinic, she paid a consultation fee of 2000 XOF out of her monthly salary of 10,000 XOF. After group family planning counselling, each woman explained their problem to a health worker. Francine told me that she had invented a story in order to convince the health worker to offer her an abortion: 'I told her that the 'author of the pregnancy' (local term to describe the father) had fled and that I had no one to support me. I added that my mother is strict and would banish me from the family'.

After Francine's explanations, the health worker decided to help her. She gave her a piece of paper on which she wrote her name and telephone number and asked Francine to forward it to another health worker (working in the same clinic) who would understand the message. After reading the note, the health worker decided to proceed with the abortion, but first told Francine she needed to do an ultrasound to confirm the pregnancy and its gestation. At a cost of 7500 XOF, the ultrasound was



unaffordable for Francine. She left the clinic and returned the following day after she found the necessary money with the support of her uncle (by pretending she was sick). The ultrasound confirmed that she was 2 months pregnant. After the ultrasound, the health worker asked her to do other tests, including serology test, blood type and hepatitis B, which cost 8500 XOF in total.

After the results of these examinations, the health worker gave her four pills, which she drew discreetly from her drawer. She instructed Francine to keep the pills under her tongue for 30 min before swallowing. Then she wrapped another eight tablets in paper and told her to swallow four tablets every 3 h. These tablets cost 15,000 XOF. Francine had no complications after this abortion. As this case illustrates, while Francine's friend directed her to abortion services in a private clinic, even with misoprostol, the cost of the abortion was more than three times Francine's monthly salary.

The experience of Anna, a 30-year-old, exemplifies how accessing abortion means not only incurring unplanned expenses and having trouble accessing abortion services but also experiencing failed abortions, frequenting several different abortion providers and intimidation (Drabo, 2019).

Anna is employed as a hairdresser and earns between 15,000 XOF to 20,000 XOF a week, but supplements her meagre income through sex work. Anna calls her boyfriend a crook and stingy because he cheats people on the internet to get money, but refuses to support her financially when she is in need. She decided to terminate the pregnancy since she was concerned that her boyfriend would take the child to his home country. As she said: "I am not going to struggle to give birth to a child and they will come and take it from me one day". When Anna was one month pregnant, she asked a friend to escort her to a woman who she knew conducted abortions in her home. According to Anna, this abortion provider is not a healthcare worker but she learned how to conduct abortions after working with a healthcare worker.

However, when Anna and her friend arrived at the woman's home, she sent them away, stating that she did not perform abortions. Anna and her friend visited the woman several times over a period of eight days before she finally agreed to help them. She asked them to pay 20,000 XOF, before placing a white product (misoprostol) in Anna's vagina and explaining that once Anna reached home, the fetus would be expelled. Unfortunately, the pregnancy was still intact after a week. After this failed abortion attempt, Anna was afraid to go back to see the woman because their previous meetings were difficult. With the help of the same friend, she decided to go to a clinic known to practice clandestine abortions. Once she reached the clinic, the man who owned the clinic requested that she pay 2000 XOF for the examination. After the examination, he fixed the price of Anna's abortion at 50,000 XOF and gave her an appointment for the same afternoon. Anna did not have enough money but decided to go to the appointment anyways with the intention of negotiating a discount. Once in the clinic, a secretary in the clinic discreetly informed Anna that she knew a place where Anna could have an abortion for less. Anna accepted the offer and was directed to the home of another woman. However, when Anna reached the woman's home, the lady rejected Anna and threatened to call the police. Anna was not able to convince the woman to conduct the abortion until the clinic

secretary escorted her. Finally, the woman agreed to perform Anna's abortion in her house using aspiration at a cost of 30,000 XOF.

Although Francine and Anna's experiences differ, they illustrate that, despite the influx of misoprostol, obtaining an abortion in Ouagadougou is a costly and often stressful process. The availability of misoprostol outside the formal healthcare system may not guarantee access nor a successful abortion for less well-resourced and connected women. In addition, given that illegal abortion often obeys the rule of 'no one knows', in case of failure, women do not hold the abortion providers accountable. Instead, they go to official health facilities to get support for treatment if complications occur, or resort to another abortion provider, like in Anna's case.

Furthermore, intermediaries often exercise control over the process of diverting the drug into the hands of women; many women are vulnerable to exploitation by providers of the drug on whom they are dependent. Conversations with women revealed that some women who need to access misoprostol become victims of sexual harassment or abuse from abortion providers. Claudine, a 24-year-old student, explained her experience with one informal abortion provider:

This man, everybody knows him...He tried to date me and asked for my phone number but I refused. One day I asked for his help because one of my friends wanted to get rid of her pregnancy. He came home and placed the tablet inside...Then he showed us the remaining tablets and told me that my friend must have this last one to finish the abortion. However, that she was not going to get it until he received my telephone number. Since that time, he disturbs me.

In another case, Lisa, a 34-year-old restaurant owner, became friends with a 19-year-old student, who was a regular customer. The student confided in Lisa that she encountered trouble while seeking misoprostol for an abortion. As Lisa explained to me:

It would have been interesting for you to meet this girl...She suffered a lot because she told me she was pregnant and did not want her parents to know about it. However, she had no money to do the abortion. X [a known abortion provider] helped her to abort using a pill but on the condition of having sex with her...without a condom.

Some women reported that they chose to self-abort in order to avoid harassment, though doing so incurs the risk of inappropriate use of abortion drugs. For instance, Sali, a 21-year-old woman working in a pub, got misoprostol from a friend, who did not tell her how to use it. She took the entire tray at the same time (14 tablets) and she was later admitted to hospital due to dizziness and pelvic pain. Abortion service providers confirmed in interviews that although many women know about misoprostol and that it can be used to induce abortion, few women know the appropriate dosage. This shows how access to misoprostol does not necessarily guarantee a safe abortion.

## **Discussion and Conclusion: Safe Access to Safe Abortion**

In this chapter, I have shown that understanding access to misoprostol for safe abortion requires going beyond the analysis of formal policies and institutions to study people's actual micro-practices. Despite a legal and regulatory framework that aims

to restrict the use of misoprostol for induced abortion, some health workers and drug vendors in pharmacies successfully divert misoprostol for illegal abortions, and some women successfully domesticate it for use in their own homes. The availability of misoprostol outside the formal healthcare system seems to reduce the cost women pay for induced abortion, corroborating findings from other studies (Ngai et al., 2000; Leone et al., 2016; Singh et al., 2018; Moland et al., 2018). Even so, improved access to misoprostol does not necessarily equate with *safe* access to safe abortion (Drabo, 2019).

In fact, much like de Zordo's findings from Brazil (De Zordo, 2016), my study suggests that there is an inequality of access to misoprostol; some women have bargaining power because of their social status and can easily access misoprostol, whereas others cannot. For some women, the route to access is through a network of drug vendors, health workers and sex workers, while others are able to get it directly from private pharmacies or NGO clinics. My findings resonate with a recent study from Ouagadougou showing that misoprostol is used predominantly among women who have attended secondary and post-secondary education and women who have high socioeconomic status (Baxerres et al., 2018).

My findings contribute in several distinct ways to the literature on the topic. First, inequities in access to healthcare innovations are often pictured in terms of dichotomies between urban–rural residence and poverty status (Singh et al., 2018). Meanwhile, my analysis highlights inequities in access to abortion or abortion drugs between people within the same geographical area, as is the case in Ouagadougou. Second, though my study affirms the importance of social networks or 'abortion management groups' in accessing abortion within legally restricted settings like Burkina Faso (Ouedraogo, 2015), the notion of an abortion management group does not fully capture the fact that the management of abortion often occurs through loose, occasional, networks rather than cohesive bounded groups, as I have shown. By circulating misoprostol in their close social networks as a gift, however, even poor women may break the access networks often controlled by health workers and drug vendors and in some instances domesticate the drug for their use at times and places they decide. Finally, my analysis challenges predominant technical definitions of 'safe abortion' that focus on the outcome of the abortion procedure and the professional competence of the operating agent (World Health Organization, 2015). While the diversion and domestication of misoprostol may increase women's access to safe abortion and make it possible to relocate abortion practices to guesthouses and other places, the process is not always conducive to safety. In some cases, the diversion of misoprostol creates conditions that allow the unpleasant treatment or even sexual abuse of vulnerable women. Thus, for some women, the route to accessing a safer abortion, medically speaking, can be unsafe. Access to misoprostol therefore does not necessarily guarantee a safe abortion.

By apprehending misoprostol in its dynamic uses, this study shows how global policies on drugs such as misoprostol can mask social inequalities and power relations around its uses. Actors advocating for safe abortion and policy makers can learn from this Burkinabe example, which shows that a drug like misoprostol, regardless of its properties and its therapeutic effectiveness, cannot alone ensure safe abortion. Indeed, for misoprostol to solve the problem of unsafe abortion

globally, women need to be able to access it equitably and safely. However, as long as its use occurs within a legally restrictive context like that of Burkina Faso, the actors and networks that emerge to fill the access gap will not treat all women equally or well, and safe access to safe abortion remains somewhat elusive.

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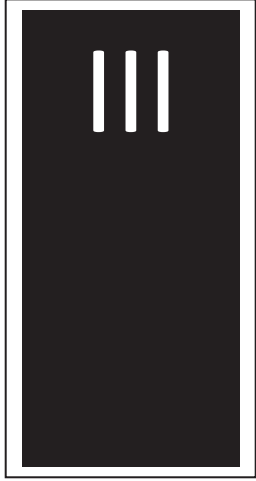
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Article

# A Pill in the Lifeworld of Women in Burkina Faso: Can Misoprostol Reframe the Meaning of Abortion

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**Abstract:** In Burkina Faso, induced abortion is socially stigmatized, condemned, disapproved and legally restricted to cases of rape, incest, fetal malformation or endangerment to the life of the mother. Many women often resort to unsafe procedures to induce abortion, which puts their health at great risk. Misoprostol, which is officially restricted to the treatment of postpartum hemorrhage or post-abortion care, is also used illegally by women to terminate their pregnancies. Misoprostol represents an addition to the existing abortion methods, such as vacuum aspiration, which health workers have often used to induce abortion clandestinely. Many women also use misoprostol to self-induce abortions, replacing abortifacients such as herbal teas, potions, high doses of antimalarial drugs, or bleach. Despite the changes that occur in abortion access due to the use of misoprostol, little is known about what the drug means to its users and how this meaning can in turn influence the meaning of abortion. The aim of this paper is to describe how the use of misoprostol to terminate pregnancy contributes to changing women's perception of the meaning of abortion. This paper is based on ethnographic fieldwork conducted between March 2016 and February 2017 in the city of Ouagadougou, Burkina Faso. By examining the relation between the use of misoprostol and the meaning that women give to abortion, this study found that women experience abortion either spontaneously or using emergency contraception with misoprostol. Through the experience of women, this paper claims that the meaning of abortion should be seen as a social construct and fundamentally rooted in individual practices and experiences rather than being subject to dichotomist global discourse.

**Keywords:** misoprostol; women; abortion; ethnography; Burkina Faso

## 1. Introduction

Abortion is a complex subject that has given rise to intense debate over its “definition” and its social, political, and legal status. In general, the needs of women are not always taken into account during these debates [1]. Hence, the relevance of looking at the meaning that they give to an “interruption” of pregnancy, because their attitude towards abortion could depend on the meaning given to that interruption. The aim of this paper is to describe how the use of misoprostol to terminate pregnancy contributes to changing women's perception of the meaning of abortion and its experience.

Misoprostol is a drug that entered in the global market in the late 1980s, and it was originally produced for the prevention of gastrointestinal ulcers [2]. Misoprostol is also used in obstetrics and gynecology to induce labor, to prevent and treat postpartum hemorrhage, and to manage spontaneous abortion [3]. It is also gaining dominance worldwide as a drug that can be effective and safe to end a pregnancy when used at the right time and with the right dosage under the supervision of trained health professionals [4]. Given that sub-Saharan African countries have the highest rates of maternal mortality worldwide due to the consequences of abortion and hemorrhage [5], public health actors have advocated for increasing the availability and accessibility of misoprostol in order to reduce maternal

deaths [6]. Abortion in the second trimester of a pregnancy can be performed by the administration of misoprostol using a variety of dosages and routes of supply [7,8]. This includes diagnosing and dating the pregnancy, administering the drug following instructions on appropriate use [9]. For example, although misoprostol is described as a safe method to terminating a pregnancy, it uses requires an appropriately trained provider in order to meet safety [10]. Therefore, accessing misoprostol does not necessarily guarantee safe abortion if the modalities of it uses are not respected. Improper use of misoprostol can lead to life-threatening complications such as collapse, bleeding and fever [11]. Moreover, a recent report on the issue of abortion worldwide suggests that clandestine abortion in legally restrictive settings is becoming relatively safer as misoprostol is replacing harmful methods [12]. Since 2005, the World Health Organization [8] has recognized misoprostol as a life-saving drug and recommended it on the list of essential medicines, although only “where permitted under national law and where culturally acceptable” in recognition of the controversial nature of misoprostol for use in induced abortion [8]. This stipulates that misoprostol be subject to specific use according to the social and political contexts of countries.

In Burkina Faso, induced abortion is socially stigmatized, condemned, disapproved [13] and legally restricted to cases of rape, incest, fetal malformation or endangerment to the life of the mother. Misoprostol is officially restricted to the treatment of postpartum hemorrhage and post-abortion care. Misoprostol also circulates informally in cities such as Ouagadougou and is often referred to locally as the ‘abortion drug’. Misoprostol represents an addition to the existing abortion methods, such as vacuum aspiration, which health workers have often used to induce abortions clandestinely. Many women also use misoprostol to self-induce abortions [13–16], replacing abortifacients such as herbal tea [17], potions, high doses of anti-malarial drugs, or bleach [4]. Misoprostol does indeed diversify abortion access sources, because its marketing in pharmacies and drug stores makes it possible to access the drug in secrecy [18]. Despite the changes that occur in abortion access due to the use of misoprostol, little is known about what the drug means to its users and how this meaning can in turn influence the meaning of abortion.

This study fits into the perspective of anthropological studies on the use of misoprostol to induce abortion by looking at how the drug can reframe the meaning of abortion for some of its users [18–20]. For example, De Zordo [19] shows how, in Brazil, induced abortion was tolerated morally among women who use misoprostol to induce abortion. Hardon and colleagues [20] discussed how girls use misoprostol in the Philippines for menstrual regulation (a euphemism for early abortion). Drawing on insights from this body of literature, this paper will discuss how using a pill rather than an invasive procedure could change the meaning of induced abortion from the perspective of women.

## 2. Materials and Methods

This paper is based on ethnographic fieldwork conducted between March 2016 and February 2017 in Ouagadougou (Burkina Faso). I focused on women’s perspectives of and experiences in seeking out abortion, including medical abortion using misoprostol. I conducted participant observation in streets and their marketplace, interacting regularly with the various women and drug vendors. I observed pubs and the streets of Kwame Nkrumah, a main thoroughfare with many hotels, restaurants, pubs, frequented by men and women who work as waitresses or sex workers, often referred to collectively as “*les filles de nuits*” (girls of the night). This gave me opportunity to start conversation around the issue of abortion and to negotiate in-depth interviews with some of the women, who, because of their work, are at risk of unintended pregnancy, abortion and their consequences [21].

In order to understand the context of drug sales and the interactions between drug sellers and consumers, I conducted participant observations and informal discussions with street drug vendors by spending time with them in their marketplace. During events such as The Panafrican Film and Television Festival of Ouagadougou, the public authorities officially establish a merchant street where traders come to expose their products. Drug vendors participate in these activities by exposing and selling their product for one week. I stayed in the store of one of the drug vendors who was selling

non-Western contraceptive methods and other drugs purchased by women. The long hours spent waiting there (3 to 6 h) gave me both an opportunity to talk with both the drug vendor and some of his clients.

In addition to participant observation, I conducted in-depth interviews with 46 women (in the perspective of the broad PhD research) about their reproductive trajectories, their perceptions and practices of contraceptive methods and abortion drugs and the decision-making processes and networks involved in the procurement of misoprostol. Health care workers assisted me in identifying women who had sought family planning and post-abortion care and who were willing to participate. I used my social network to identify other participants from the general population. This consisted of asking women who were more or less close to me (neighborhood, former classmates, friends, etc.) and who agreed to participate in this study. Subsequently, I relied on these women to access other women (friends of my friends, etc.) who were also willing to participate in this study. Of the 46 women I interviewed, 16 reported that they had undergone induced abortions in the past. These 16 interviews form the basis of the analysis in this paper. Apart from two women, I met in post-abortion care services, the rest of the women (14) I met outside of a health center. Among this group, nine were single women, four were co-habiting with a man, two were married and one was widowed. Seven of these women were working as servers in a pub, three were students, three were petty traders, one was a maid, one a housewife and one a public servant. Five of the women in this group had had more than one abortion. Together, these 16 women had 23 abortions between 2010 and 2017. Ten of them reported using misoprostol to terminate one or more pregnancies (five women used it vaginally with the support of the abortion provider and six women used it orally themselves or after receiving instruction from abortion providers or friends), while other methods included manual vacuum aspiration potassium permanganate, Chinese pills and recipes made from plants. The ten women who reported using misoprostol for abortion did so on pregnancies ranging from 1½ to 4 months. Among these women, one used the drug without confirming the pregnancy while the other one did not know how far along she was in her pregnancy at the time of using misoprostol. Seven out of the 16 women's interviews are used in this paper because their cases are more illustrative of women's abortion experiences and related issues.

### *2.1. Data Analysis and Ethical Issues*

I conducted interviews in French, Mooré or Dioula depending on participants' preferences. I also fluently speak the three languages. I tape-recorded the interviews (except 3 of them who were more comfortable with note taking) and they were transcribed verbatim. Interviews lasted between 20 min and one hour and 30 min. A research assistant transcribed the interviews and those recorded in Mooré or Dioula were translated into French. I did the final editing, checking all the transcripts in order to ensure accurate transcription and translation.

The data analysis process was guided by a thematic approach that was both deductive and inductive [22]. The data was reviewed with certain preconceived categories derived from previous studies and from my own research experience [1,13,23]. For examples, theme such as women's reproductive experience, affective trajectories, relationships with contraception and abortion technologies and the decision-making processes in relation to these methods are illustrative of the deductive analysis. The inductive analysis concerns themes that emerge directly from the data using inductive coding. In this framework, the transcripts were carefully read in order to identify the emerging themes. Phrases and sentences related to abortion experience and the way they define or perceived it were coded in the margins of the transcript sheets.

The themes identified in the research drew out historical details of the women's lives, while pointing out the facts, practices or events that dealt with their reproductive life. The events were related to each other by taking into account their chronology. The approach makes it possible to see, for example, when and how the prevention, the occurrence and the termination of a pregnancy

occurred in the person's life; the motivations and facts that contributed to the occurrence of these events, their perception and so on. This data summarized the stories of women.

Cross checking research material (interviews, field notes, and observation) and the summary of women's stories allowed me to write a "problematized" portrait, i.e., a portrait of a research participant around an issue they experienced and described based on a specific context [24].

I used some of the portraits and excerpts from interviews with women that have used misoprostol to terminate a pregnancy to illustrate my findings. The quotes that I have chosen to use to illustrate the findings have been translated from French to English. I obtained ethical approval for this study from the Ethical Committee of Burkina Faso and the Norwegian Centre for Research Data. I read out loudly informed consent forms to the research participants, who provided oral consent by their own wish. Oral consent was also the most suitable because of the sensitivity of the topic for both health care providers, drug vendors and women. Despite reading informed consent, I tried to remind my participants of my good intentions. For example, I made women understand "My goal is not to judge but to understand...". This attitude allowed me to establish a climate of trust with participants so that they would feel comfortable talking about their reproductive life experiences. I told all participants they could withdraw from this study at any time or choose not to participate in this study. The names of participants cited in the quotes are pseudonyms.

## 2.2. Abortion Debate and the Role of Technology

Abortion remains a moral issue that raises debate that is usually framed as a battle between the fetus's right to life and the woman's right to choose [25]. At this level, different conflicting points of view are clear: one position maintains that the fetus is a life and claims that abortion should be criminalized [26]. Another position counters this argument by asserting that the fetus is not a life and that policy must be directed toward protecting a woman's ability to control her own body by letting her choose whether to have an abortion or to carry a pregnancy to term [26]. The players in this debate involve a list of non-exhaustive actors, including religious actors, less well-known opponents of abortion, feminist groups, medical circles, family planning agencies, etc. [25,27]. Beyond discussion about the status of the fetus and the rights of women, debate also concerns a struggle over what the goal for abortion policy should be [27]. At this level, the debate focuses on different issues ranging from the recognition of abortion as a public health problem to the recognition of abortion as a woman's right [1].

The issue of abortion as a public health problem has been addressed at various conferences and has been focused on the health consequences of unsafe abortions considered as major public health problems. Unsafe abortion, described as a cause of maternal morbidity and mortality in countries where abortion is illegal [28], has introduced discussions on the decriminalization of abortions. However, opponents of the decriminalization of abortion hardly recognize the link between illegality and the associated risks. For the latter, decriminalization would increase the occurrence of unsafe abortions, despite recent scientific evidence that has shown that the prevalence is low and relatively stable in countries where abortion is legal [29] in contrast to countries where abortion is illegal [1]. Moreover, given the lack of global consensus, emphasis has been placed on the prevention of abortions through universal access to family planning services, post-abortion care and the need for governments to guarantee individuals the exercise of sexual and reproductive rights.

Regarding abortion as women's rights, none of the international conferences have admitted a right to abortion and referred the decision back to the national authorities of countries [30]. As a result, in many countries, the legal status of abortion is more about health concerns than rights, as claimed by feminist movements since the 1960s.

Furthermore, technology has not remained on the sidelines of the abortion debate. Callahan [31] described in five points how scientific development could reframe abortion debate through several implications [31]. First, the scientific developments have legal implications, as they can be significant in undercutting important factual assumptions underlying earlier court decisions. Second,

the developments may have psychological implications, because new evidence may motivate people to think in different ways about their beliefs. Third, the scientific developments can have social implications in placing abortion in a different social context. Fourth, the developments may have political implications by serving as effective political capital if cleverly deployed. Fifth, the developments can have moral implications by prodding people to examine their consciences or by provoking new moral arguments.

In practical terms, technological changes, such as fetal photography, ultrasound, advances in care for preterm infants, and fetal surgery, have facilitated personification of the fetus and challenged previous constructions of boundaries between fetus and infant [31,32]. The antagonist groups have used these different technologies in order to strengthen their positions. For example, the actors who think that women have the basic human right to decide when and whether to have children have debated the relevance of appropriate gestational age limits [32], while actors advocating against abortion have helped to shape this debate by using fetal images and by interpreting them in ways that suggest abortion is equivalent to murder [33]. As we can see, technology is making the abortion debate more complex, because different groups of people exploit it to support their perspectives, which contributes to perpetuation of the antagonistic positions. However, the complexity of the abortion debate involves historical and cultural meanings specific to each country [27].

### *2.3. Understanding the Social Context and the Illegal Circulation of Misoprostol*

The Burkinabe context offers a complex landscape for studying the use of misoprostol to terminate pregnancy. Burkina Faso is a sub-Saharan African country located in West Africa. The average age at first marriage is 17.9 years old, with nearly one-third of girls married between 15 and 19 years old and two-thirds married by the time they turn 24 years old [34]. The fertility rate was estimated at 5.71 children per woman by the World Bank in 2017. In Burkina Faso, sexuality in marriage is expected as elsewhere. However, sex also occurs frequently outside of marriage [35]. This increases the risk of unintended pregnancies. According to Bankole and colleagues [4], one-third of all pregnancies each year in Burkina Faso are unintended, and one-third of unintended pregnancies are ended by abortion. In rural areas, the abortion rate is slightly lower (22 per 1000 women) as compared to that in urban areas (42 per 1000).

The practice of abortions, like in many societies [36], is subject to social disapproval in Burkina Faso. Abortion experiences are intimate and confined to silence [35]. Many women often resort to unsafe procedures to induce abortion, which can create great risks to their health. In general, half of women who induce their own abortions are estimated to experience complications as compared with approximately two in 10 women who go to health care providers [4] offering illegal abortions. The government's principal policy response to the issue of unsafe abortions has been the implementation of a post-abortion care policy to treat the complications of unsafe abortions [30,37] through manual vacuum aspiration and misoprostol.

My fieldwork focused on Ouagadougou, a city of 2.7 million inhabitants [38], which is also Burkina Faso's administrative and economic center. In Ouagadougou, there is no access to abortion care in the public sector, except in the circumstances stipulated by law. Comprehensive post-abortion care services are offered in secondary and tertiary health care facilities and in some primary health care facilities in the public sector as well as in certain private sector and Non-Governmental Organizations facilities [39]. Misoprostol can be purchased for reproductive health indications by prescription in hundreds of pharmacies in the city [40]. There are mechanisms in place in health facilities to prevent misoprostol from being used outside the framework of the management of incomplete abortions and in the treatment of postpartum hemorrhage (Ouattara et al. 2019 forthcoming). However, the permissiveness of the drug distribution system in Burkina Faso that allows individuals to access the drug without showing a prescription generates conditions that favor illegal abortion [16]. In this context, the circulation of misoprostol obeys the same logic of drug exchange in developing countries where Van der Geest and Whytes [41] have shown that it often circulates as a commodity that can be sold and purchased [41].

Drug vendors in pharmacies, health workers and sex workers are among the actors involved in the network that enables women to access misoprostol illegally (Drabo 2019 forthcoming).

#### 2.4. *Misoprostol Is Changing Access to Abortion*

The abortion experiences of women show that misoprostol has changed access to induced abortions, because it allows them to have abortions discreetly and at a relatively cheap cost as compared to other abortion methods, such as manual vacuum aspiration. Women described how misoprostol could be used at home, in a pub, guesthouse or any place to induce abortion. Here, 23-year-old Awa (single) explains her experience when she resorted to misoprostol to terminate a three-month pregnancy:

“My boyfriend contacted a doctor who gave us an appointment in front of a guest house. My boyfriend paid for the room and then waited outside. I went inside with the doctor who put a white pill inside me. After that, I did not see him again. When I arrived home, I started bleeding a bit and it came out.”

These examples show how misoprostol enables clandestine abortion services to work discreetly, by removing the procedure from the health care setting where providers may risk prosecution if complications occur. In addition to meeting the need for discretion, misoprostol also changes the cost of abortion services.

Women report that abortion with misoprostol was relatively affordable, around 15 USD, as compared to illegally induced abortions using manual vacuum aspiration, which can cost 45 USD. However, the price of misoprostol varies depending on how the product is accessed. It is relatively cheap when women procure it to have a self-induced abortion as compared to when they use a health worker. However, some women I spoke with had an abortion without paying money, because their acquaintances gave them misoprostol free. For example, Diane a 35-year-old woman lived with her partner for 17 years with whom she had two children. Her partner did not want another child. After she announced her third pregnancy, he asked her to have an abortion and threatened to leave her if she kept the pregnancy. Diane decided to contact one of her friends, a medical doctor, to obtain misoprostol, and he gave it to her free of charge. As she explained:

“When I had my problem, I got the product for free. A friend helped me to get it from another friend. He did not buy it either, because they are both health professionals and they mutually support each other. The other friend could not refuse, because he knows that one day he may also need help (not only abortion) from my friend.”

Furthermore, some of the research participants described how they obtained misoprostol from female friends or relatives who had used it to self-induce abortion. These female friends or relatives gave the remaining pills from the packet they purchased as a gift. Although she has never had an abortion, one woman in my study confided that she has misoprostol because her cousin gave her some tablets in case she would need them one day. She interrupted the discussion to locate the tablets and showed me a blister pack with six tablets missing. This fact of giving misoprostol means that the abortion of one woman can allow the abortion of another woman.

In sum, misoprostol through the changes that it brings in terms of access to abortion is a response to the demands or the expectations of women seeking to terminate a pregnancy within the context of the restrictive abortion law in Burkina Faso.

#### 2.5. *When Misoprostol Turns Induced Abortion to “Spontaneous Abortion”*

Misoprostol plays an important role in the abortion experiences of women given that it has diversified pregnancy termination methods in addition to existing methods, such as manual vacuum aspiration and curettage. By describing their use of misoprostol and the abortion process, some of the participants, such as Adjara, stated that the drug interrupts pregnancy like a spontaneous abortion.

Adjara is a 37-year-old woman who started using contraceptives at the age of 18 with the intention of avoiding 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.” Later on, for fear of illness and being overweight, she decided to stop taking contraception after 4 years of use. Immediately after this cessation, she experienced three pregnancies before her marriage and decided to get rid of them. The first pregnancy was interrupted by a curettage performed by a health worker. She terminated the last two pregnancies herself using misoprostol, which she discovered through one of her acquaintances. Adjara declared that she used misoprostol the first time on a one-and-a-half-month pregnancy and for the second time, she did not confirm the pregnancy before using the drug. Comparing the two methods of abortion (curettage and misoprostol), Adjara said:

“Since I discovered misoprostol I did not do curettage again. The curettage is very painful, and you do not know who is fiddling you. I do not know how to express it, but it is very painfully. While with misoprostol, you swallow and the next day you have small stomachache; then, you go to the toilet, you feel it goes down slowly, and then you take antibiotics after. It is a bit like having a spontaneous abortion...”

The example of Adjara shows that past abortion experiences can play an important role in the way women build their perceptions about abortion, because the fact of having experienced several abortions makes it possible to make comparisons between different episodes and methods. We see how Adjara refers to her three abortion experiences to state her preference for misoprostol over curettage. She justified her preference for misoprostol based on its process, which is less painful and interrupts pregnancy like a spontaneous abortion. Furthermore, Adjara’s reference to spontaneous abortion, even though she has not reported having had one, can express her attempt to describe a pregnancy termination with a positive note given that spontaneous abortions in Burkina Faso are morally accepted as compared to induced abortions.

#### *2.6. Misoprostol Is Like Emergency Contraception Pill*

The use of emergency contraceptives is part of the reproductive experience of women. In general, women use emergency contraceptives when they are in a situation that they consider to be at risk for pregnancy. Through their discourse during interviews and informal discussions, the use of emergency contraception, which they commonly call “norlevo”, is a common practice to avoid pregnancy, as testified by the following example of Veronique. Veronique is a 35-year-old woman living in a union with a man, and she was a mother of two children at the time of the interviews. She identified herself as a religious person, meaning she is practicing a religion (Protestant). Veronique used a contraceptive method; the first time was in 2012 after her second delivery by resorting to pills and injections. Afterwards, she stopped taking them, because she was not living in the same city with her partner. She said, “To take contraceptive methods is to say that we are sexually active. I don’t live with my husband, and I am not sexually active. So, I decided not to take contraception anymore.” However, Veronique confided in me that she has resorted to emergency contraception in case of sexual intercourse during a period in which she is likely to become pregnant. She said, “For us who are religious, it is acceptable, because nothing proves that there was going to be a pregnancy.”

Furthermore, although most women I interviewed admitted to have used the morning-after pill at least once in their life, some of them found it ineffective in avoiding a pregnancy as explained by Nina, a 39-year-old woman who ironically declared: “Yes, I know I’ve used this before, but it does not work all the time. If you want take a pill of few seconds, it does not work.” Through this quote, Nina stresses that if there was a pill of some second unlike that of 72 h (morning-after pill), it will not work for everyone. Due to the uncertainties associated with the efficacy of the morning-after pill, some of the women I interviewed prefer to resort to misoprostol once they have a delay in the onset of menstruation: “Yes, because as soon as you know you have a delay, you take it.” These words of Adjara were confirmed during informal discussions I had with women in a maquis in the city of Ouagadougou. In this environment, the use of misoprostol is often trivialized, because the girls refer to the drug to tease each other. As explained by Flora (33 years old, living with a man) during informal

discussion: “When you see a friend who is sad or who is looking sad, you propose to her to slip two tablets of miso in her beer in case there is a delay in her period that is worrying her” (laugh).

As can be seen, the experiences and discourse of women shows that they tend to substitute misoprostol for an emergency contraception pill, especially since some of them do not hesitate to describe misoprostol by equating its mode of action with that of “norlevo” (emergency contraception). As does Flora, a single woman who during the interview has declared to having already resorted to misoprostol to stop a pregnancy (the pregnancy was two months): “If you know the effect of norlevo then you know the effect of misoprostol (Cytotec). When you take it after your dangerous period, it is only blood that you will see coming out later. . . .” (Flora, 33 years old, living with a man).

Comparing misoprostol with emergency contraception pills makes one think about the following syllogism: if using emergency contraception does not mean having an abortion and misoprostol acts like emergency contraception, then the use of misoprostol does not necessarily mean you are having an abortion. Furthermore, it should be noted that women who tend to have a positive discourse on the use of misoprostol as a method of terminating a pregnancy have used it either on a confirmed pregnancy at an early stage (1 to 2 months) or after a delay in their menstrual cycle (2 weeks to 1 month).

Examining the relation between the use of misoprostol and the meaning that women give to abortion, we see that women view an abortion either as spontaneous or as emergency contraception. This reference to spontaneous abortion and emergency contraception appears to be a way for women to confess their abortion with understatement in order to present a picture of abortion that is socially and legally acceptable. Indeed, in Burkina Faso, spontaneous abortion is considered a misfortune that can generate compassion for the “victim,” while emergency contraception reminds one of contraception, meaning a prevention of pregnancy before conception, which is also an issue that the women accept compared to abortion (which is a termination of the pregnancy after conception). The fact that they answer the question as to whether they have already voluntarily terminated a pregnancy by naming their experience shows that women do not deny that what they performed was an abortion, but they simply decide to present it in other way thanks to misoprostol and its mode of action.

### *2.7. Women’s Abortion Experiences with Misoprostol*

The use of misoprostol for abortion is not equally available to all women. Indeed, women’s stories show that access to abortion is not a foregone conclusion. A forthcoming paper on the domestication of misoprostol by women highlights that terminating a pregnancy with misoprostol outside legal frameworks does not always turn out as expected. In this regard, some women can obtain medical abortion with misoprostol by resorting to private clinics. Women who do not have money to buy misoprostol are more likely to be victims of sexual harassment or sexual abuse from men that offer abortion services. Some women will perform self-abortion by administering drugs, but in most instances, they resort to misoprostol in contexts characterized by uncertainties related to a lack of information about the pregnancy and the drug. As illustrated by the case of Charlotte:

Charlotte, 26, is a student and mother of a 7-month-old child. After the birth of her child, Charlotte chose not to use any contraceptive method because she feared the side effects. Resuming sexual intercourse, Charlotte said she was afraid of becoming pregnant because her partner refused to use condoms. After a two-month delay in her menstrual cycle, Charlotte thought she was pregnant despite the negative results of a pregnancy test she did herself. To remove doubt, she decided to terminate the “suspected” pregnancy. Charlotte decided to go to a pharmacy in the city center of Ouagadougou to obtain an abortion pill, she explained:

“Once in the pharmacy. I told him that I have a young child and I realized that I am pregnant. It will be difficult for me to keep this pregnancy and to manage the other child. After my explanations, he told me there is a product that can terminate the pregnancy but without a prescription, he cannot sell it. However, he later reassures me that he can help me if I have money to buy the drug. The drug cost 11,000 of the West African CFA franc (XOF) (1 US equals approximately 590 XOF). I did not have enough money that day and I had to return to the pharmacy 3 days later after getting money from a



friend. The drug vendor gave me a tablet of misoprostol and told me that I should swallow four pills three times every four hours. However, before I left the pharmacy, he told me he is not responsible for any problem that will happen . . . ”.

Charlotte’s experience shows her willingness to use misoprostol without being sure of being pregnant. In addition, she has access to the drug from the seller, who shows her a regimen without knowing her gestational age and his disengagement from the rest of the abortion process. It is clear that in these circumstances, the risk of the improper use of the drug becomes clear. Later in the discussion, Charlotte confessed that she resigned herself to not using the drug until the pregnancy becomes evident. Another woman, Samira, a 21-year-old woman (single) working in a pub, obtained misoprostol from a friend with minimal knowledge on the misuse of the product. During the interviews conducted with her, she confided that she was three months pregnant and decided to terminate it. She obtained misoprostol from a friend who did not tell her how to use it. She took the entire tray of pills at the same time (14 tablets). A few minutes later, she was admitted to hospital due to dizziness and pelvic pain.

For other women, accessing abortion means experiencing failed abortion as illustrated by the case of Anna, a 30-year-old who became pregnant with her foreign boyfriend. She was not sure about how far along in the pregnancy she was but thought that it had been more or less three months since the baby was conceived. She worked as a hairdresser and earned between 15000 XOF to 20000 XOF a week. She supplemented her meagre income through sex work. She decided to terminate the pregnancy since she was concerned that her boyfriend would take the child to his home country. As she said: “I am not going to struggle to give birth to a child and they will come and take it from me one day”. When Anna was one month pregnant, she asked a friend to escort her to a woman who she knew that conducted abortions in her home. According to Anna, this abortion provider was not a health care worker, but learned how to conduct abortions after working with a health care worker.

Anna and her friend visited the woman several times over a period of eight days before she finally agreed to help them. She asked them to pay 20,000 XOF, before placing a white product (I assumed it could be misoprostol) in Anna’s vagina and explaining that once Anna reached home, the fetus would be expelled. Unfortunately, the pregnancy was still intact after a week. After this failed abortion attempt, Anna was afraid to go back to see the woman because their previous meetings were difficult. With the help of the same friend, she decided to go to a clinic known to practice clandestine abortions three weeks later after the first attempt. Once she reached the clinic, the man who owned the clinic requested that she pay 2000 XOF for the examination. After the examination, he fixed the price of Anna’s abortion at 50,000 XOF and gave her an appointment for the same afternoon. Anna did not have enough money but decided to go to the appointment anyways with the intention of negotiating a discount. Once in the clinic, a secretary in the clinic discreetly informed Anna that she knew a place where Anna could have an abortion for less. Anna accepted the offer and was directed to the home of another woman. Anna did not know anything about the professional background of the woman, beyond that she offered abortion services. The woman performed Anna’s abortion in her house (abortion provider) by aspiration at a cost of 30,000 XOF.

Anna’s experience illustrates that accessing misoprostol outside legal frameworks may not guarantee access nor a successful abortion. Given the illegality of the abortion, in the case of failure, women are not able to hold the abortion providers accountable. Rather, they go to official health facilities to receive support for treatment if complications occur, or resort to another abortion provider until they are “satisfied”, such as in Anna’s case. In such circumstances, women may face unplanned expenses or experience delays in receiving the right care after starting the abortion process.

### 3. Discussion

The aim of this paper was to describe how the use of misoprostol to terminate pregnancy contributes to changing women’s perception of the meaning of abortion. Based on ethnographic research, I have highlighted how the use of misoprostol allows women to access abortion at a relatively cheap cost, which corroborates with findings from other studies [7,42].

For women who have access to misoprostol, its use to stop a pregnancy influences how they define abortion, especially in view of the fact that misoprostol, as a technical object, can be a meaning-making vehicle [43]. That is to say, that it can impose a certain frame of thought [44]. By examining the relation between the use of misoprostol and the meaning that women give to abortion, this study has shown that, with misoprostol, women experience abortion either as spontaneous or as using emergency contraception. Thus, with misoprostol, the experience of abortion becomes different due to some of the following reasons: the early abortions women have allows them to see blood instead of a “constituted” fetus after expulsion; the process of pregnancy interruption is less painful, leading to a post-abortion period with less trauma; in addition, the fact of anticipating the use of misoprostol without confirming a pregnancy when they have a delay in their menstrual period allows them to maintain doubts about abortion and to equate the use of the drug to a contraceptive method. Furthermore, this reference to spontaneous abortion and emergency contraception allows them to present a picture of abortion that is socially, legally and morally acceptable. These findings confirm other anthropological studies [18,19] that have highlighted how misoprostol changes the meaning of abortion by making it a morally acceptable practice. The attitude of women reminds us that the meaning of abortion depends on the beliefs, perceptions and experiences of individuals. Thus, women’s “encounter” with misoprostol and its mechanisms of action help to “shape” their perception of abortion.

Furthermore, one of the major changes that misoprostol has brought to the abortion experience of women is the relative autonomy it guarantees from physicians and their instruments [45]. As with other abortion drugs, such as RU-486 (mifepristol), misoprostol is a technology that allows women to be actors during the abortion procedure, which is in contrast with surgical methods that reduces them to the status of patients and dependent on medical actors to terminate their pregnancy [46]. This situation reduces the social and medical constraints that limit access to abortions (ibid). However, the context in Burkina Faso allows for some nuances, because women do not have equal access to abortion drugs, such as misoprostol. For example, a recent study in Ouagadougou has shown that the use of misoprostol is predominantly among women who have secondary and post-secondary education and who have high socioeconomic status [14]. Indeed, the introduction and use of misoprostol in Burkina Faso in the context of the restrictive abortion law gives opportunities to individuals with strong social networks and negotiating power to access misoprostol relatively easily, while those less powerful still struggle (Drabo 2019 forthcoming). Access to misoprostol through friends and drug vendors in pharmacies for abortion does not necessarily equate with quality, because the experience of women in this study and other studies has shown that the information provided by individuals working in pharmacies and drug shops is often poor, with few advising an effective regimen or not giving information on potential complications if they occur [47].

For poor women, the purchase and the use of misoprostol outside legal frameworks means risking sexual violence, misusing the product due to a lack of proper information with the risk of health complications, and experiencing inefficiency of the product when purchased from illegal abortionists, and the additional costs that this entails in the abortion-seeking process. These issues are in line with the findings of Zordo [19], who has shown in her studies in Brazil that the lack of legal access to misoprostol and to information on its safe use makes its purchase sometimes difficult and its use dangerous for low-income women. Despite accessing misoprostol, these women’s abortion experiences fall into the category of “less safe” abortion because of the lack of adequate information and support from trained individuals [10]. In addition, when abortion providers use their power to exploit women’s vulnerability by abusing them sexually, it is clear that for these women, the route to accessing a safer abortion, medically speaking, can be unsafe (Drabo 2019 forthcoming). The legal context of accessing misoprostol contributes to perpetuating forms of violence that undermine women’s sexual and reproductive health rights.

Understanding abortion experience, the risks associated with the use of misoprostol and inequalities in drug access could elicit policy changes by raising awareness of constraints related

to the informal access of misoprostol and its health consequences. That is what makes this ethnography valuable.

This study has some limitations. The findings presented are from interviews with a relatively small group of participants recruited in the capital city and, thus, the views are not necessarily generalizable to all women. In particular, the majority of the women interviewed for this paper were recruited outside of health care facilities with the exception of two. The sample therefore is unlikely to represent the full spectrum of women's abortion experience, particularly those who are admitted to hospital for post-abortion complications.

#### 4. Conclusions

Through the experiences of women cited in this paper, the meaning of abortion should be seen as a social construct and fundamentally rooted in individual practices and experiences. Rather than being subject to dichotomist discourses within the arena of global health. Furthermore, changes brought by misoprostol in term of access to abortion and the relative cheapness of abortion that results from the use of the drug make it likely that women will continue to resort to it. Providing women with knowledge about proper usage of the drug will be a relevant public health intervention that could reduce the health risks associate with the improper use of misoprostol. The Uruguay model could inspire this intervention by involving pharmacists/drug vendors and health workers in the process of evidence-based information on the safe use of misoprostol [48].

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## Appendices

### **Interview guides**

Interview guide for women

Day of the interview: Hours: Time of the interview: Place:

Language of the interview: Recorder: Yes or No

### **Socio-demographic characteristics of women**

Identification number

Age: Home (sector or district): Contact:

Ethnicity: Religion: Education: Marital status: Occupation:

### **Reproductive health history;**

- How old were you when you first had sexual intercourse?
- How many times have you been pregnant (including this pregnancy loss)?
- How many children born alive have you had? How many children born alive are still living? How many pregnancy losses (stillbirths, miscarriages, abortions)?
- Was the current pregnancy planned or unplanned?

### **Future reproductive intentions;**

- Do you hope to have another pregnancy? How many more children would you like to have? How many more children would you? husband/partner like to have?
- When do you plan to have another pregnancy? How do you plan to delay your next pregnancy? How do you plan to avoid getting pregnant again?
- Are you and your partner in agreement about your future reproductive intentions?
- **Contraceptive methods and the use of abortion drugs (fertility control)**
- What does the words FAMILY PLANNING? CONTRACEPTION mean to you?
- What do you consider to be the ideal number of children?
- How can a woman avoid or delay pregnancy?
- Which contraceptives methods do you know?
- Where and from whom did you get information about them?

- Have you ever used or not any contraceptive methods? What was the reason behind the use? Which methods (traditional and or modern contraceptives)? If not ask the reason why she never use a contraceptive method?
- Were you using a contraceptive method when you became pregnant this time? Which method were you using? Why do you think the method failed? Does your partner or family support your use of a method to delay or avoid pregnancy?
- What is your opinion on the different methods of contraception?
- Is there any other method that a woman can use to control her fertility (probe, emergency contraceptive, abortion)?
- Where can a person have access to an abortion drugs? What are the cost
- Have you ever used any abortion drug (probe traditional, biomedical)? Which one (description or name)? When did you use? Where did you get? How much does it cost?
- How do you perceive the relation contraceptive methods vs abortion drugs? According to you what could be the reason for using one method rather the other?
- **The abortion (for post abortion care patients)**
- Do you know any circumstances that allow for legal abortion in Burkina Faso?
- What was your reaction when you knew you were pregnant (expected or not expected to be pregnant)? Who was (parents, spouse, friend) aware of your pregnancy? If so what was their reaction? If not, why they have not been informed?
- Did you have some problems (social, financial, health) during pregnancy? What problems? Can you please tell me more about?
- Can you please tell me more about the condition under which you lost your pregnancy (try to find out if it was spontaneous or induced, to understand the experience of this fact...)? What was the age of the pregnancy?
- When have you decided to seek help? Have you decided to perform it by yourself or it has been decided by someone else? Where have you been first?
- Which method did you used or has been used to induce abortion. Probe on the type of methods, traditional, abortion drugs, chirurgical? How much did it cost? Who were paying for it?
- What is your opinion on abortion?
- Do you think this abortion made or will make some changes (consequences) in your life?
- What are your opinions about abortion (to legalize or not)?





- What distinguished these two methods?
- What are your preferences regarding the promotion, distribution and availability of contraceptives methods?
- How do you perceive the relationship between unwanted pregnancy and abortion?
- What should be done to prevent unwanted pregnancies? The abortions?
- How is your structure / institution working on these issues?
- What are the issues addressed? What justifies these choices?
- How do you put these issues into practice on the ground? (Probing activities)
- What are the target beneficiaries? What for ?
- Perception on for family planning and contraceptives methods and abortion

### **Policies, practices on contraceptives methods and abortion drugs**

- What are the laws, policies and guidelines related to the promotion and distribution of contraceptive methods and abortion drugs
- What is the usual process to introduce a medicine in health facilities or pharmacies? (Probe for contraceptive drugs and others drugs like abortions)
- What are the actors involved in this process (International, national, local)? What is the relationship between them?
- What are the distribution channels (supply) of different drugs
- Do you think that these medicines are uses outside of approved indications or channels of distribution? (Probe for the reasons) Do you have examples?
- Are there any political challenges to the promotion and distribution of contraceptive methods and abortion drugs?
- Are there any sociocultural challenges to the promotion and distribution of contraceptive methods and abortion drugs?
- Which conflicting choices and positions may guide or influence the availability and the use of contraceptives? Abortion drugs?

Knowledge, perception use of misoprostol?

- Knowledge on misoprostol?
- When and where have you heard about misoprostol for the first time?
- This medicine is used for which purpose?
- Under which conditions should it be prescribed...)?
- And you, for what purpose do you prescribe it? Do you need a permission to prescribe it?
- To whom do you prescribe it?
- When was the first time you use it? For which purpose? If there were no misoprostol, what would you have done if Misoprostol was not there?
- Is there any other drug that can replace misoprostol or vice versa? What are the advantages and limits of each of them
- In your opinion, do caregivers share the same opinion on the use of this drug? Are Patients familiar with this medicine? • How do they react when you prescribe it?
- Where can we get access to it? How much does it cost? Is it difficult to access?
- How do you perceive these drugs? What does it represent to you?
- Do you think everybody should be allowed to prescribe it? To sell it?
- According to you what role do you think Misoprostol should play in reproductive health management in Burkina Faso in general? Abortion specifically?
  
- **Perception of abortion and PAC**
- What is your opinion on abortion?
- According to you, what are the factors involved in the voluntary interruptions of pregnancy?
- Have you ever, in your experience, been dealing with requests for termination of pregnancy?
- What were the motivations of these applications?
- How do you react to this type of application?
- What should be done to prevent unsafe abortions?

## Ethical Approvals



Seydou Drabo

Senter for utvikling og miljø (SUM) Universitetet i Oslo

Boks 1116 Blindern

0317 OSLO

Vår dato: 06.06.2016

Vår ref: 48007 / 3 / BGH

Deres dato:

Deres ref:

### TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 16.03.2016. Meldingen gjelder prosjektet:

*48007                                      The social life of medicines in Burkina Faso: an ethnographic study of the circulation of contraceptives and abortion drugs*

*Behandlingsansvarlig      Universitetet i Oslo, ved institusjonens øverste leder*

*Daglig ansvarlig                      Seydou Drabo*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 31.12.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Belinda Gloppen Helle

Kontaktperson: Belinda Gloppen Helle tlf: 55 58 28 74

Vedlegg: Prosjektvurdering

Personvernombudet for forskning



Prosjektvurdering - Kommentar

---

Prosjektnr: 48007

#### PURPOSE OF THE STUDY

According to the notification from the purpose of this study is to examine the use and trade of legal and illegal medicine and means to prevent and terminate unwanted pregnancy in the area around Ouagadougou.

Furthermore the study seeks to analyze the process through which such drugs circulate within the health system. Moreover the researcher aims to deepen the understanding of the social meaning of the drugs to those who are using them and their significance within their social worlds.

#### INFORMATION AND CONSENT

The sample will receive written and oral information about the project, and give their consent to participate. The letter of information received 26.05.16 is well formulated. However the end date (31.12.18) of the project has to be added to the letter with information saying that all personal data will be deleted/anonymized at that date.

#### RECRUITMENT

Recruitment of the patients :

According to the notification form post abortion care patients will be identified and recruited by workers at the health center/hospital. The Data Protection Official for Research presupposes that in order for the duty of confidentiality to be maintained the employees at the health center/hospital has to inform the patients about the research project. If the patient is interested in participating in the research the patient can get in touch with the researcher or the patients has to give her permission for her contact information to be forwarded to the researcher.

The Snowball Approach :

According to the notification form female sex workers will be recruited by using the snowball approach. We recommend that persons already participating in the project will recruit new members by forwarding the researchers enquiry and ask interested persons to get in contact with the researcher, or that the person in question gives her permission to forward their contact information to the researcher. The Data Protection Official presupposes that the recruitment process is done in a way that fulfils the requirement of voluntarily participation and confidentiality.

#### SAMPLE AND GATERING OF DATA

The sample consists of around 50 people divided into several different groups that will participate in the study through different forms of data gathering:

1. Post abortion care patients
2. Policy makers, pharmacists, health care providers and drug vendors - persons involved in the implementation of contraceptives and drug policies, or in the promotion and the distribution of contraceptive drugs and/or abortion drugs.
3. Women who use contraception and abortion drugs and those who does not. Married and unmarried living in Ouagadougou and its rural municipalities.
4. Men who are married or unmarried living in Ouagadougou and its rural municipalities.
5. Students
6. Sex workers/prostitutes

#### Duty of confidentiality:

Health care providers are bound by their duty of confidentiality. This means that it's important that the interviews, focus group and observations are conducted in such a manner that confidential personal information is not gathered. Please be aware that it's not only names, but also identifying background information that needs to be left out of the interviews and observations. Examples can be age, gender, time, diagnoses or/and specific events. We presume that you are careful about using examples during the focus groups and interviews. The Data Protection Official presupposes that you will not be gathering any personal information about any of the health care worker's patients.

#### Direct observations:

The different groups of participants that will be observed are:

- Drug vendors
- Actors in workshops, conferences, seminars and campaigns on family planning/abortion.
- Interactions between health care providers and women in family planning services.

As stated in the email correspondence with the researcher (26.05.16) no personal information will be gathered while conducting observations for the project. As this part of the project is anonymous this part of the project is not subject to notification. However we recommend that participants that are being observed are informed about the research project as this is good research ethics. Please note that the researcher cannot gather personal information about participants that are not informed and has not given their consent.

Shadow client methods:

Shadow client methods - the shadow client will act as a client to obtain medicine/drugs. The researcher will not gather any personal information about the vender while conducting this part of the study. Therefore this part of the project is anonymous and not subject to notification.

We have been in contact with NESH (cf. phone correspondence 03.05.16) to discuss the ethical side of the shadow client method. According to NESH they don't find this problematic. First of all, this part of the research will take place in the public sphere (a market or place of commerce), no personal information will be gathered, the project does not have an experimental design and the tradeoff of the project is bigger than the disadvantage for the person being studied.

Focus group discussions:

The different participants that will participate in the focus groups are:

- Two groups of women and men
- NGO actors
- Health workers

Please note that in the focus groups it's important the questions being discussed are formed in such a way that they can be answered in an assembly. This is especially the case when the topic of the discussion is of a sensitive character. In some cases it might be a good idea that the participants sign a confidentiality agreement.

In-depth interviews :

In-depth interviews will be conducted with:

- policy makers
- pharmacists
- health care providers
- drug vendors
- men and women (including current users of contraceptive and/or abortion drugs)
- post abortion care patients
- female sex workers

Medical journals/records:

According to the notification form personal information would be gathered from medical records. However according to the researcher (cf. email 26.06.16) this is wrong, therefore we have changed this part of the notification form.

#### ETHICAL CONSIDERATIONS

The researcher has experience in conducting this kind of fieldwork and has experience in conducting interviews about sensitive topics. In his research proposal there is a section devoted to different ethical issues that must be considered. In addition NESH has given a statement about the project and the Ethical Committee of the Ministry of Health of Burkina Faso has given their approval for the project.

#### THE RESEARCH ASSISTANT

A trained female research assistant will be used for some parts of the project:

- To facilitate the main researchers' interaction with female participants on sensitive topics
- Organizing and conducting focus groups, negotiate access and deal with administrative requirements for recruiting and interviewing people from health facilities.
- Spend time in post-abortion care services to help identify and put the researcher in contact with patients.



She has to sign a confidentiality agreement. In addition, if the research assistant is from an external institution (not UiO) a data processor agreement should be made. For advice on what the data processor agreement should contain, please see: <<http://www.datatilsynet.no/English/Publications/Data-processor-agreements/>>

### THIRD PERSONS

The researcher might receive some information about third persons. Third person can be family, friends or colleagues. Please note that identifying information about third persons should only be registered when necessary for the scientific purpose of the project. The information should be reduced to a minimum and should not be sensitive, and must be made anonymous in the publication. As long as the disadvantage for third persons is reduced in this way, the project leader can be exempted from the duty to inform third persons.

### SENSITIVE INFORMATION

There will be registered sensitive information relating to sex life and health issues in the interviews with the post abortion patients, sex workers and the two groups of men and women.

### INFORMATION SECURITY

The Data Protection Official presupposes that the researcher follows internal routines of Universitetet i Oslo regarding data security. If personal data is to be stored on portable storage devices, the information should be adequately encrypted.

### OTHER PERMISSIONS


The Data Protection Official presupposes that the researcher will get permission from the heads of the different health facilities in which he is going to observe the practice.

### THE END OF THE PROJECT

Estimated end date of the project is 31.12.2018. According to the notification form all collected data will be made anonymous by this date.

Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:

- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)



MINISTERE DE LA SANTE  
MINISTERE DE LA RECHERCHE  
SCIENTIFIQUE ET DE L'INNOVATION  
COMITE D'ETHIQUE POUR  
LA RECHERCHE EN SANTE

DELIBERATION N ° 2016-3-024

la TITRE DE LA RECHERCHE

«La vie sociale des médicaments au Burkina Faso : une ethnographie de la circulation des contraceptifs et des abortifs (médicaments perçus ou officiellement connus comme abortif)».

2. REFERENCE DU PROTOCOLE

Version non précisée

3. DOCUMENTATION

Le protocole de recherche Le  
reçu de paiement

4. REFERENCE DU DEMANDEUR

Demandeur : Drabo Seydou Doctorant en Anthropologie de la santé

5. SITE DE LA RECHERCHE

Burkina Faso

6. DATE DE LA DELIBERATION

02 mars 2016

7. ELEMENTS EXAMINES

- Conception scientifique et conduite de la recherche;
- Soins et protection des participants à la recherche;
- Protection de la confidentialité des données du participant à la recherche;
- Processus de consentement éclairé

Budget de la recherche;

- CVS

- **8. OBSERVATIONS**

- Prévoir un consentement pour les participants à l'observation directe.

- **9. MEMBRES AYANT SIEGE**

Dr Séni KOUANDA

.

Dr Djénèba SANON/OUEDRAOGO;

Dr Ida  
SAVVADOGO;

Dr Minoungou Germaine;

Dr Maminata TRAORE/COULIBALY; Mr  
Mathias SAM;

**10. AVIS DU COMITE Avis Favorable l a RESERVES**

**12. RECOMMANDATIONS**

Ouagadougou, le 02 mars 2016

Le Rapporteur



Dr Germaine MINOUNGOU/COMPAORE

Le Président



Pr Séni KOUANDA, Directeur de recherche  
*Chevalier de l'Ordre des Palmes Académiques*