Title:
"You Have No Way to Hold Them Back": Contraception, Sexual Pleasure and Gendered Social Norms in Burkina Faso

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Abstract:
The liberatory power of contraception for women has long been a central pillar of the reproductive rights movement. In recent years, demographers have proposed an array of mechanisms to link contraceptive use to women's empowerment even more broadly, including that delaying first pregnancy helps girls stay in school, and that having fewer children increases women's labor force participation. This framing of family planning as uniquely empowering, however, fails to grapple with the ways that contraception can be deployed in support of regressive ideologies, not just progressive ones. Commonly associated with the "sexual revolution" and freedom from oppressive patriarchal norms, contraception has just as notably been linked with ideologies of eugenics, scientific racism, and medical misogyny. Yet the complex ways that contraceptive use and childbearing take on social meaning, and the impact of entrenched gender norms on this process have received scant attention from demographers.

We use data from 17 focus group discussions in Burkina Faso to examine how gendered norms around childbearing and marriage affect social perceptions of contraceptive use. Using thematic analysis, we find that contraceptive use in the pursuit of sexual pleasure is strongly stigmatized, with this type of user considered "prostitutes" by their peers. In contrast, contraceptive use for family stability (e.g., birth spacing or to satisfy one's husband) is strongly endorsed. We use these findings to understand how gender norms affect the social perceptions of fertility and contraceptive use, exploring how contraception may be used both to contest as well as to further entrench gendered oppression.

Introduction

In the field of global public health, scholars and advocates paint contraception as the quintessential tool of women's empowerment. The United Nations Population Fund, for example, writes that "family planning is central to gender equality and women's empowerment," while the World Bank argues that family planning "empowers women and girls to have more control over their lives and well-being."[1,2] And indeed the empowering and emancipatory nature of contraception for women has been a central pillar of the reproductive rights movement for decades, as it has worked to expand access to contraception to women around the globe. In addition to the fundamental right to bodily autonomy, a growing collection of instrumental arguments has been offered in recent years to tie contraceptive use to women's empowerment. The proposed mechanisms for these instrumental arguments include that 1) delaying first pregnancy helps girls stay in school; 2) having fewer children helps increase women's labor force participation; and 3) contraceptive use helps women gain greater decision-making roles in their households, among many others.[3–5]

This dominant framing of contraceptive use as inherently and uniquely empowering, however, fails to grapple with the ways that contraceptive technologies can be deployed in support of regressive ideologies in addition to progressive ones. Although contraception has often been employed as a technology of women's liberation from oppressive patriarchal norms, it has just as notably been deployed as a technology of oppression, linked with ideologies of scientific racism, medical misogyny, coloniality, ablism and more.[6,7] The way that forced sterilization was employed by the eugenics movement to limit the reproductive capacities of those deemed "unfit" to parent is one well-known example.[8] Sterilization abuse has been a problem around the world, with people targeted along axes of race/ethnicity (and indigeneity in particular), physical and intellectual disability, coloniality, and more.[9–14] Abuse of other methods

of contraception, including both short-acting methods like the oral contraceptive pill and longer acting methods like IUDs and contraceptive implants, has also been well-documented around the world.[6,15–18]

Despite an abundance of legal, journalistic and historical evidence documenting the ways that contraception can be deployed in ways that are profoundly repressive, the framing of contraception as an almost miraculous tool for women's empowerment has faced little pushback in the contemporary global health and development literatures. A fast-growing subfield of demographic research has been focused on measuring and quantifying the exact relationship between contraceptive use and women's empowerment. One major focus of this research has been to tease apart the directionality of the relationship, testing the degree to which contraceptive use leads to women's empowerment and also to which women's empowerment leads to contraceptive use.[19–24] Some of this research has included a critical focus on gender norms and gendered expectations, but more generally this body of research has taken a less sophisticated approach to understanding gender.

The longstanding impoverishment of demographic reproductive health research on the question of gender is well-documented, and many of these well-known shortcomings affect this subfield as well.[25–28] These include (but are by no means limited to) the conflation of gender with "women" so that any research about women is assumed to have "gender" component, and the overwhelming absence of "men," masculinities and patriarchy from the discourse.[25,29] This body of research on women's empowerment and contraceptive use also tends to reproduce the ideology that more contraception is necessarily better, often using contraceptive uptake as the marker of success in their analyses. This uncritical framing of contraceptive use as a universally

positive outcome has left little room for a more nuanced understanding of the ways contraception can be used to both enhance as well as limit reproductive autonomy.

There has been, however, a strong focus in the demographic reproductive health literature, on cultural attitudes toward family planning, often framed as "stigma," which serves as a "barrier to access" that can limit the success of family planning programs seeking to promote contraceptive uptake.[30] And indeed, the study of stigma is central to the study of sexual and reproductive health (SRH). SRH topics are, by definition, intrinsically tied to some of the most intimate parts of human behavior, which means they tend to be considered private, sensitive, and taboo. As a result, SRH researchers have paid a great deal of attention to the ways that stigma can affect access to and use of critical reproductive health services. Research on stigma is particularly well-developed in the SRH sub-fields of HIV/AIDS and abortion,[31–35] but there is also widespread agreement among scholars that sociocultural norms around sexuality and gender play an important role in shaping both contraceptive attitudes and behaviors.[36–42] One particular focus of this research has been on adolescents, and the ways that contraceptive use among teens is stigmatized as the behavior of "bad girls" and those deemed sexually promiscuous.[43–46] Additional family planning research on provider bias and barriers to access has shown how contraceptive use is stigmatized among the nulliparous due to concerns that biomedical contraception can adversely impact future fertility and prospects for motherhood.[30,47–49]

But while much demographic reproductive health research has focused on the ways that different sociodemographic factors such as age or parity might affect stigma or societal acceptance of family planning, the vast majority of this research has tended to focus on single factors (such as marital status, for example), often in isolation. Comparatively little attention has been paid, in contrast, to the ways that the intersections of these characteristics affect social

understandings of childbearing, family planning, and contraceptive use. And yet, we also know that it is precisely at the complex intersections of these identities that the intricacy of social and structural processes such as contraceptive access and decision-making can best be understood.[50–55] Viewing different aspects of social identity in isolation from one another can leave researchers with an incomplete -- often impoverished -- understanding of what they seek to study, leading to urgent calls from researchers to explicitly incorporate an intersectional lens in public health research.[56–58]

In this paper, we use focus group data from two research sites in Burkina Faso to examine how social roles, gender norms, and stigma around family planning vary across complex, intersecting identities of age, marital status, and student status, and perceived life trajectory. We explore the ways that sociodemographic factors can take on a range of potential meanings and implications for family formation, childbearing, and contraceptive use depending on how they intersect with each other, and the ways that these intersections render someone a legitimate or illegitimate user of contraception in the eyes of their community. We further examine the gendered implications of this for women, as they seek to maintain their social status while navigating through shifting societal ideals of motherhood and domesticity.

Methods

Research Ethics

This research was reviewed and approved by 1) The Office of Human Research Administration at the Harvard T. H. Chan School of Public Health in Boston, USA; 2) Le Comité d'Éthique pour la Recherche en Santé du Ministère de la Santé de Burkina Faso in Ouagadougou, Burkina Faso; and 3) Le Comité d'Éthique Local du Centre de Recherche en Santé de Nouna, in Nouna Burkina Faso. Written informed consent was obtained for all adult

participants. Written parental informed consent was obtained for all minors, in addition to assent from the minor. Names appearing in this manuscript are pseudonyms. No identifying information was retained about the participants.

Data

The data for this analysis come from a mixed methods parent study at two research sites in Burkina. The qualitative phase of this study consisted of semi-structured in-depth interviews (IDIs) and focus group discussions (FGDs) to obtain a broad understanding of contraceptive autonomy in Burkina Faso. Due to important differences between urban and rural SRH experiences, we conducted fieldwork in both the Ouagadougou Health and Demographic Surveillance System (HDSS) in Burkina Faso's capital city, as well as 11 rural villages in the Nouna HDSS. Eight local data collectors were engaged to carry out interviews in Mooré, Dioula, and French. Data collectors were trained to emphasize the study goals, in addition to non-directive probing and value-neutral interviewing techniques.

The data used in this analysis come from the 17 focus group discussions we conducted with women of reproductive age (15-49 years-old), including a total of 146 individual respondents. We used key informants and our local research collaborators to develop our sampling strategy, which was purposive and designed to maximize variation and obtain a diversity of opinion across a wide range of sociodemographic characteristics including religion, age, marital status and educational level.[59,60]

The conversation guides were pre-tested with local key informants for clarity and content. Questions included standard sociodemographic background information, as well as probes on previous use of contraception, past experiences at family planning services, reproductive desires, fertility intentions, gender norms in decision-making, and cultural views on

childbearing. Data collectors were free to take an unstructured approach to prompting when necessary to allow the respondents to guide the discussions based on their concerns and interests, within the greater scope of autonomy and quality in family planning. All interviewers were audio-recorded, translated into French and transcribed verbatim with personal identifiers removed. Researchers and field supervisors monitored the data closely during the time of collection for quality and made changes to the tools as needed throughout the fieldwork period.

Data analysis

Our multidisciplinary study team used a modified grounded theory approach based on Straus and Corbin to guide or team coding for the analytic phase of this work.[61,62] After initial data familiarization, our team of four coders and one senior reviewer began using Dedoose software to free code first few transcripts. Based on these free codes, we generated an initial list of codes that we organized into code families. Once we generated this initial code list, each transcript was then independently coded by at least two coders using Dedoose software. We convened weekly team meetings to discuss potential changes to the code list (new codes, collapsing codes together, etc.) as well as memos, and other issues of note that had arisen during the previous week. Through this iterative process, we generated main themes and performed axial coding to help us link concepts to one another, make meaning from the individual codes, and promote an intersectional undersetanding.[62] We used an explicitly intersectional lens to examine how the meaning of various codes and themes varied in relation to one another. Here, we present these findings with illustrative quotes.

Results

Emergent themes presented here center around the ways that contraceptive use is rendered socially legitimate or illegitimate based on a constellation of intersecting

sociodemographic factors, including age, marital status, parity, student status, and motherhood. We find that the ways that these intersections take on meaning is in relation to the woman's life trajectory, and to her path towards the ultimate social destinations of wife and mother. Overall, we find that contraceptive use is considered legitimate and condoned by the community when that use is framed in service of becoming of a better wife and/or mother, having a stable and healthy home, and better fitting in with gendered notions of motherhood and domesticity. Examples of this include using contraception to space births or avoiding great grand multiparity in the pursuit of improved child health and high-quality motherhood to existing and future children.

In contrast, we find that contraceptive use is generally considered illegitimate and condemned by the community when it is seen as a means for women to evade gendered social expectations of devoting oneself to motherhood and the home. Examples of this include contraceptive use among the young, unmarried and childless, as well as among married women whose decision to use family planning is perceived to be less in the interest of optimal motherhood and more in the pursuit of sex for women's pleasure, especially outside of marriage. We also find a notable (albeit temporary) exception to this rule: the woman's student status and perceived life trajectory. In contravention of a singular focus on marriage and motherhood, we find widely permissive attitudes toward the contraceptive use of young, unmarried, nulliparous women if they are students, and if the community perceives that their life is building towards something bigger that could be ruined if she gets pregnant too soon. This exception is temporary, however, as even these students are subjected to the strong expectations that, after a short delay, they will eventually make marriage and motherhood their priorities.

The legitimacy of contraceptive use in the service of motherhood and marriage

There were many instances in which contraceptive use was strongly endorsed by the focus group respondents. There was widespread agreement among participants that the use of a contraceptive method is not only an acceptable choice, but almost an obligation for married women who have had children already. These narratives revolve around the notion of birth spacing and the perception that shorter interpregnancy intervals both present a grave danger to the wellbeing of the children, and imperil the mother's ability to properly care for them. This notion that birth spacing is the primary legitimate use for contraception is evident in this excerpt from Nikki:

> **Nikki**: In my opinion anyway, it [contraception] is to space out births, so that we can space out our births, so that they [our children] can flourish. The mother also, you also will be in good health, the child will also be in good health.
>
> FGD12 (rural, married, Christian, over 25)

The notion of birth limiting was also sometimes invoked along with birth spacing by focus group respondents as an appropriate use of contraception in certain circumstances. Using contraception to prevent more births than a family can properly care for was discussed by participants, often using the language of "suffering" in these conversations. Here, we see examples from two different focus groups:

> **Liz:** If you are married and you take medicine [contraception], that is good. Because if you do not take medicine and you have a lot of children. There will not be anyone to take care of you and you will suffer right along with your children.
>
> FGD14 (rural, unmarried, Muslim, under 25)

> **Hannah**: What causes a woman to adopt a method of contraception, it is when you have a lot of children, you cannot take care of them. So, if you have children, at some point, you need to limit your births. Even if you have not yet gone through menopause [if you are reaching the final reproductive years], you need to limit like that to better take care of your children and to better educate them. Before, our mothers had ten or twelve children, but now if you do that you will suffer, deh! [to emphasize her point]
>
> FGD13 (rural, married, Christian, over 25)

Liz's powerful evocation of "suffer[ing] right along with your children" evokes a lack of social support or a social safety net to help take care of large families, while Hannah draws an explicit break with the lives of "our mothers" and the larger family sizes that were common in the recent past. In this way, we can see how some social norms around family size and family formation are changing, while the fundamental expectation of motherhood is not. We can note that Liz takes care to specify that this use of contraception is only legitimate "if you are married."

This emphasis on avoiding suffering and being able to care for one's children leads to an emphasis on a married couple's financial position:

> **Lucie:** Me, I am falling into poverty, living in poverty. They say a young girl who is not in school, who has to sell oranges [an example of low-paying menial labor], who is used to doing that, if she enters into a household [gets married], she must use a method [of contraception] because she sees the reality of things these days. Life is expensive and life conditions are harsh.
>
> FGD7 (urban, unmarried, Muslim, under 25)

While many other participants emphasized that contraception could only be legitimately used after someone has children, for Lucie, the use of contraception may be condoned even among a newlywed who does not yet have children, given the context of precarity and extreme poverty. In the hypothetical situation that Lucie relates to her own life of poverty, she discusses how the harsh conditions of modern urban life almost necessitate contraceptive use, to avoid bringing a child into the world that one cannot care for.

As well as discussing contraception as a means to help care for children and become a good mother, focus group respondents also discussed the legitimacy of contraceptive use to promote marital harmony, solve disputes with husbands, and keep the domestic peace:

> **Interviewer:** What do you think about women who just gave birth and use a method of contraception? The women who just gave birth and who use contraceptive methods.
>
> **Amanda**: You could say that that makes sense, because you can't just say you give birth. Some men, even right after you get home from the hospital, if you give him the chance, he will do it [have sex with you] …You'll purse your lips [to pout or express disapproval] often but you will do it to save your household.
>
> FGD2 (urban, married, Catholic, over 25)

Amanda's invocation of the need to "save your household" implies that women refusing sex to their husbands in the wake of childbirth would cause marital strife and even the dissolution of the marriage. In this context, using contraception to avoid a pregnancy while meeting a husband's expectations for sexual availability at all times and preserving the union "makes sense" to Amanda, as the use of contraception is in the service of domestic stability and satisfying one's husband.

The illegitimacy of contraceptive use in pursuit of sexual pleasure and the "high life"

In contrast to the scenarios above, in which promoting child health and meeting the sexual desires of one's husband were considered socially legitimate uses of contraception, our focus group respondents also shared with a variety of situations in which they view contraceptive use as unacceptable and worthy of social condemnation. Many of these situations involve young women and unmarried women, for whom out-of-wedlock sexual activity is stigmatized more broadly.[63] We see some example of this in the following exchanges from across different focus groups:

> **Morgan:** There are people that say that you are still too young, and you are going to use family planning, why are you taking this medicine, you, a little girl, you are going to take family planning that your mother even did not take, that is not normal. If you are not of age to use and you use contraception that can make you sick. When you start to swallow the pills, you will start to gain weight, people will see you in a bad light, they will suspect you are swallowing medicine. These curious people will ask you what you are eating, and you will grow like that. If you say nothing, they will tell you that you're faking it and you already took medicine at the CSPS [the health clinic]. You would be the topic of all the gossip in the village.
>
> **Interviewer**: What would they say?
>
> **Morgan**: They will criticize you everywhere in the village. They will say that you are not a good girl, that you went to the CSPS to take medication that they swallow without their parents knowing.
>
> FGD15 (rural, unmarried, Christian, under 25)

Molly: In my opinion, contraception is not good for young girls. Because when they use it, it's to roam around like a vagabond. And when they start roaming, it is difficult to get them back on the right path. Using contraception, it is not good for young girls. When they know they can't get pregnant, they won't stay close anymore. You have no way to hold them back.

Tiffany: It's not even possible

Molly: Well, after they get married, after their marriage they still want to continue [roaming sexually]. I tell myself it's not good for young girls to use contraception. I think they when they grow into women, and they have two or three kids, then they can use contraception.

FGD4 (urban, married, Muslim, over 25)

Interviewer: If a girl is not married and is not with a man and she is using contraception, what do people think of that?

Olivia: They think that they are big girls and that they want to live the high life and flirt with men, and that is the reason they start taking contraception…If you find out that she is of age, there is not a problem, but it is when she is not of age that it is a problem. If you know that you are not of age, you should stay at home!

FGD12 (rural, married, Christian, over 25)

In these passages, from both Muslim and Christian groups in groups in both urban and rural areas, we see a widespread condemnation of contraceptive use for woman who use it in the pursuit of sexual freedom. When women are perceived as not yet having met their social

responsibilities to marry and bear children, their desires for sex and their use of contraception are considered to be illegitimate. The evocative language that the respondents use associates contraceptive use with "wanting to live the high life," not being a "good girl" and even wanting to wander sexually between different partners like a "vagabond." These passages make clear that it is not a matter of simply being young *or* unmarried *or* nulliparous that renders contraceptive use and sexual activity so taboo for these women, but rather, the combination of all three. The reasons that respondents cite are concerns that non-marital sexual activity will lead young girls down a sort of garden path toward sexual wantonness and away from a morally upstanding life. And Morgan's quote makes clear, contraceptive use among the young, unmarried and nulliparous can leave the user open to widespread speculation, gossip and contempt in her community. Molly's fear that "they won't stay close anymore" and that, "you have no way to hold them back" suggests an anxiety that young, unmarried contraceptive users young, unmarried contraceptive users will be able to evade gendered social control in a broader sense.

Even when younger women get married, social approval of their contraceptive use may not necessarily be forthcoming. Many participants shared the belief that married women should not initiate contraceptive use until they have had at least a couple of children, cementing their social status not only as wives, but as mothers. We can see this in a quote from Beth:

> **Beth**: If you are married and you take medicine without already having children, it is not good. It is when you have a child during your marriage that you can start taking them. People say that if you are married without any children and you take them, they say that you do not want to stay within your household [you want to cheat on your husband].
>
> FGD14 (rural, unmarried, Muslim, under 25)

Addie offers a similar position to Beth, stating that multiparity is the key to rendering contraceptive use legitimate among married women:

> **Addie:** The [married] women, in any case, can use it, but the young girls, if you have not yet given birth, you cannot use it. If you use it anyway, it is not good because you do not know if you will be able to give birth, or if you will not be able to give birth. You can also become infertile -- use it and then never be able to give birth because you are infertile. If it is a woman with however many kids, you know that if you use it, even if you never give birth again, it is not a problem.
>
> FGD8 (Urban, unmarried, under 25)

What is implicit in many of these excerpts but made explicit by Addie are anxieties that use of biomedical contraception might negatively impact a woman's future ability to bear children. Given the importance in Burkinabè society of motherhood to a woman's broader standing in her family and in her community, the risk of losing future fertility is considered too great a risk to respondents like Addie, and one that should not be undertaken by those who have not yet fulfilled their roles as wives and mothers.

Focus group respondents were quite clear about importance of parity to the legitimacy of contraceptive use to married women:

> **Interviewer:** What do people think about married women who use contraception? For example, of a married woman uses contraception, what do people think about her?
>
> **Sally:** Someone who's married and who has children or does not have children?
>
> **Interviewer:** Both

Sally: If you get married, you don't yet have kids, and you use contraception, then you don't want any [kids]. Or else, you still want to go out and indulge yourself. If not, you get married, and you wait for God to allow you to have a child before going and doing what you like. Will the man even let you go do that? Why did I marry you then? It's not because of us two alone…

Jessica: … It's outside [of the marital home] that you want to be. Otherwise, a person cannot get married and use contraception without having a child. That means that, between your husband and you, there is no love.

Bonnie: People will say that you have someone outside with whom you take pleasure.

FGD3 (urban, married, Muslim, over 25)

As we see in this example, the distinction between someone who has already had a child and a nulliparous woman is foundational to how both her husband and the broader community will interpret her contraceptive use. Here, the respondents draw clear connections between contraceptive use by childfree married women, cheating on one's partner, and a lack of love between spouses.

Again here, the intersections of woman's social position are key. Although generally our respondents expressed social approval of contraceptive use for married women, the intersection of marital status with parity is complex and has important implications for women's status and social reputations. As Beth's quote suggests, what matters for how a woman's contraceptive use is perceived by her community is not just whether or not she is married, but what her motivations for contraceptive use are interpreted to be.

This variability in how the community might respond to a married woman's contraceptive use is exemplified in the following exchange:

Samantha: Family planning is good – it helps women.

Interviewer 2: If you have a newborn in your hands and you go to the CSPS [health clinic] to use contraception, what will your social circle and your community think about you?

Sandy: They'll say you love to have sex a lot.

Interviewer 2: Why will they say that about you?

[Outbursts of laughing…]

Elizabeth: It's true what she just said, but even if people think like that, we still think it [family planning] is a good thing… if you get pregnant even though your child is still small, your husband seeing you like that might go look for other woman outside. [Laughter from group]. It's better to do your injection early and then you have your peace. [Laughs]

Anna: There are some women, just one month after giving birth, they start to see their periods again. So that's why it's better to use contraception.

Interviewer 2: So, they say that women love to have sex and that's why they'll go use family planning? But what about married women who use family planning, what do people think about them? Women like you, I mean.

Anna: Some people say that these women want to relive their youths, you hear a little bit of everything [Laughter from group].

FGD11 (rural, Christian, 25-49)

This lively exchange shows that even women who are married *and* have children might still be subjected to mockery or derision if their use of contraception is perceived to be due to an appetite for sexual pleasure, rather than a concern for her children, husband, or household.

Social restrictions on contraceptive use can come not only from the broader community, but from within the intimate partnership as well. Bernadette told us:

> **Bernadette:** Some men do not allow their wives to use family planning because some women do not stay just with their husbands. If they use it [contraception], they will go be with other men in their village.

FGD16 (rural, unmarried, Christian, under 25)

The belief that a married woman is using contraception not to be a better wife to her husband, but to sleep around can have serious implications for the marriage, as Margo explains:

> **Margo**: People say a lot of things, like if you take medicine, they will insult you and if your husband is not understanding, you will lose him. It creates a lot of household disputes.

FGD12 (rural, married, Christian, over 25)

Through these quotes, we can see the various ways in which contraceptive use is rendered illegitimate, not in clear-cut ways based on isolated understandings of marital status, parity, or age, but rather in the ways that these characteristics meet each other and suggest the contraceptive user's motivations for use. If the users' motivations for using contraception might be interpreted as seeking sexual pleasure, regardless of whether that pleasure is with her husband or outside of marriage, that contraceptive use is likely to be condemned, mocked, or otherwise

stigmatized by the broader community. However, if the contraceptive use is interpreted as in service of motherhood (through healthy birth spacing), domestic responsibility (through careful stewardship of the family's resources), or wifely duties (through sexual availability to one's husband), then our focus group respondents expressed strong social approval.

The complicating roles of student status and life trajectories

One important exception we observed to these broad rules and overarching trends was student status. According to our respondents, the upward life trajectory that lies before women who excel at school, and the potential for a mistimed pregnancy to derail that trajectory was often seen as reasonable justification for contraception use, even among the young, unmarried and nulliparous for whom it would otherwise be proscribed. Many respondents expressed the belief that contraceptive use could help female high school and university students stay focused on and eventually complete their studies, rather than having to drop out to care for a child prematurely. For some respondents, the distinction between unmarried students and unmarried non-students was key:

> **Interviewer**: So, you're saying they say that those who go to school use it [contraception], and those who do not go to school don't use it?
>
> **Courtney**: Some use it to go do prostitution.
>
> **Interviewer**: So, for you, the girls that use these methods do it so they can become prostitutes?
>
> **Courtney:** For those that go to school it is understandable, but for those that do not go to school, it is for prostitution.
>
> FGD17 (rural, unmarried, Muslim, under 25)

Despite Courtney's association of premarital contraceptive use with prostitution, she nevertheless makes an exception for students, for whom she feels contraceptive use is "understandable." Other respondents expanded on the rationales behind why they thought contraceptive use among students was acceptable. According to Rachel:

> **Rachel:** If you are not yet married, especially if you are a student, they say "Ha, you need to use a contraceptive method so that you can progress in your studies"
>
> …
>
> The young women are right [to use contraception] because if you're a student, your parents are paying for your studies. If you get pregnant, often the guy who got you pregnant will abandon you to your sad fate. Your studies will end immediately. If you think about the money your father spent [on school fees], it hurts too much to think about.
>
> FGD13 (rural, married, Christian, over 25)

Rachel evokes the gendered consequences of a mistimed pregnancy for young women, underlining how the other party to the pregnancy would not face the same consequences to their educational prospects and life trajectory. Rachel also evokes the investment that the young woman's family has made in her education as a reason to protect that investment using contraception. In this way, it seems that girls' education may be opening new possibilities in terms of what women might become in addition to wives to mothers. Education is seen as an important enough factor in life's trajectory that it, in some ways, overrides other social concerns about sexual promiscuity and evading domestic expectations.

It is important to note, however, that according to most respondents, student status offers delay in the social obligation to become a mother as opposed to an overall evasion of it.

Respondents were clear that all women were eventually expected to get married and have children, and that contraception in this context for students actually serves as a way of preserving their marriageability for later. Since their schooling would likely result in a later age at marriage and a thus a wider gap between the time of sexual debut and eventual matrimony, the use of contraception was proposed to ensure that they would not have any children prior marriage, and thus protect their prospects for later:

> **June:** No young woman can get to a certain age and claim that she can abstain. So, you go in search of a way to preserve yourself while waiting for marriage. That's what I have to say.
>
> FGD10 (rural, married, Muslim, over 25)

This same motivation was also mentioned by Elizabeth, who expounded:

> **Elizabeth:** There are some girls who haven't found husbands very quickly, because they want the man of their choice, and they go back and forth between boys. So, the mother might say to her daughter, you can't abstain, but you can help yourself with a contraceptive method before you find the man of your choice. There are mothers who want their daughters to have a good husband, but if they spend too long with the boys and they get pregnant, their dreams will be reduced to nothing. Even if it's God who decides to give you a good husband, you won't get any respect when you have a child before getting married.
>
> FGD11 (rural, Christian, over 25)

Importantly, however, not everyone shared Elizabeth's belief that premarital contraceptive use was acceptable in order to preserve student' future marriageability. Olivia told us:

> **Olivia:** Ha! I do not take any medicine [contraception]! If you are not married, you are not with a man, you are a student and you are still taking medicine, what are you looking for now?
>
> FGD12 (rural, married, Christian, over 25)

Olivia's excerpt shows that, to some community members, there is no legitimate use for contraception among an unmarried young person, student or not.

Discussion

Using data from 17 focus group discussions with 146 women in rural and urban Burkina Faso, we find a complex tangle of social norms and sociodemographic factors affect the degree to which women's contraceptive use is considered legitimate or illegitimate by her community. We find that ways these intersections take on meaning is in relation to the woman's life trajectory, with a heavy focus on the ways that contraceptive use either paves the way or bars the route toward gendered expectations of marriage, motherhood, and domestic life. Broadly speaking, contraception is seen as most legitimate for birth spacing, preventing great grand multiparity, and any other use linked to promoting child health and family wellbeing. In this way, it appears that contraceptive use may be most broadly acceptable when it serves to reinscribe rather than challenge existing gender norms. When contraceptive use is linked to women's sexual enjoyment or a perceived evasion of marriage, motherhood, and other conventional gendered life goals, however, it becomes far more stigmatized.

The complex calculus that goes into deciding the legitimacy or illegitimacy of contraceptive use based on these criteria can only be fully appreciated using an intersectional lens. Whether it is acceptable for a married woman to use contraception, for example, depends heavily on her age and parity, while her age can only be understood in the context of her student

status, financial position, and other markers of life trajectory. These findings add important depth to our understanding of the complex interplay between contraceptive use, stigma, and gender norms. For family planning programs seeking to expand access and meet the contraceptive needs of Burkinabè women, understanding the complexity of these dynamics is essential.

These results also demonstrate the limits of the family planning programs that global health and development programs have out in Burkina Faso (and more broadly throughout Africa) heretofore. These programs, often conceptualized and funded in the Global North, have, for the most part taken a politically calculated approach to promoting contraception. Anticipating that strong pronatalist views and preferences for larger families would render a focus on fertility limitation controversial, most family planning programs throughout the African region instead opted for a focus on birth spacing and healthy families that they considered less likely to incite a backlash. These programs also elected not to promote contraception as something that could transgress existing gender norms or revolutionize women's sexuality by delinking sex from procreation. Instead, the strong focus on birth spacing and healthy families allowed biomedical contraception to be introduced and promoted as something that would help women stay healthy and be better mothers.

The result of this politically calculated approach has been what gender scholars call a "gender unequal" approach to promoting family planning – one that takes advantage of and reinscribes prevailing gender norms, as opposed to challenging and transforming them.[64–66] Then, as narratives of "women's empowerment" began to gain currency in global health and development circles, family planning programs have sought to integrate these narratives, again without challenging entrenched norms around women's sexuality and domestic life. While family planning programs have often discussed empowerment over past several decades, this

empowerment has been framed as largely in terms in neoliberal development terms.[67] The overwhelming focus of these arguments has been on the ways that the contraceptive use can help women avoid early childbearing and great grand multiparity, which in turn, enables them to participate more in formal education and enter the formal labor force.[68]

The simplistic view of contraceptive use as always empowering leaves little room for a more nuanced understanding of the ways that that family planning programs can limit autonomy in addition to promoting it. Ways that contraceptive programs can inhibit reproductive freedom are starting to become better documented, with a great deal of new research from the United States showing how provider biases and discrimination can lead people into using contraception they do not understand or desire.[18,69–74] Outside of the United States, this body of research is less well developed, but emergent work over the past few years has begun to show that similar racialized, gendered and classed logics are at work in the Global South as well, with the added dimension of coloniality. This research has documented violations of contraceptive autonomy in a range of African settings, including at the time of method adoption as well as the time of desired discontinuation for users of long-acting methods.[17,75–79] Others studies that have shown that a large proportion of contraceptive users in Burkina Faso are using a non-preferred method, and that they lack informed contraceptive choice.[80,81] Taken together, this body research complicates the notion that contraceptive use is necessarily always empowering for the user, and suggests that researchers and advocates should use greater caution when conceptualizing the ways that family planning programs can affect women's empowerment and reproductive freedom.

Conclusion

Perhaps as a result of the narrow view of contraceptive promotion that family planning programs have taken, contraceptive use still remains highly stigmatized outside of the limited set of circumstances in which it is thought to improve a woman's capacity to serve her husband and her children. The role of women's sexual pleasure is an understudied but essential aspect of contraceptive use and broader discussion of the emancipatory potential of family planning is necessary to move past the limited, stigmatized, and often constrained use of contraception that we observe here.[82] Rather than seeking to embed family planning programs within existing unequal gender relations, future family planning programs should seek to advance a conception of reproductive justice that affirms not only the right to parent healthy children in safe communities, but also includes a range of possibilities for sexuality that are not intrinsically tied to reproduction.[83]

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