

**Family Planning during the Postpartum Period in Ouagadougou, Burkina Faso:
A Qualitative Supply and Demand Perspective**

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Introduction

The period of postpartum non-susceptibility (PPNS) has been singled out as an important “*proximate determinant*” in inhibiting the number of children in high fertility populations (Bongaarts & Potters, 1983). In such settings, women who recently gave birth are protected from new pregnancies by long periods of breastfeeding, inducing prolonged amenorrhea. In many West African countries, the tradition of extended postpartum abstinence has offered additional protection against closely spaced pregnancies (Page & Lesthaeghe, 1981). Research shows that PPNS remains the main fertility-reducing factor in Sub Saharan Africa, even as contraceptive use is becoming more widespread (Sibanda, 1999). Brown (2007), using recent Demographic and Health Survey (DHS) data for Kenya, Zimbabwe and Ghana, demonstrates that “the combined effect of amenorrhea and abstinence [provides] natural protection from pregnancy for an average of a year or more in all three countries” (p. 499). Although this study shows that postpartum abstinence makes a difference in West Africa, most of the action in this domain is driven, as elsewhere in the world, by breastfeeding duration and patterns (the median duration of breastfeeding is between 20 to 23 months in these three countries). In this framework, women who are non-susceptible during the postpartum period (either abstaining or amenorrheic, or both) are removed from the pool of women contributing to the fertility rate; they are classified as not at risk of becoming pregnant. While an individual woman is at risk of becoming pregnant when amenorrheic (since ovulation precedes the return of menses), this risk is small at the aggregate level, and is neglected in those calculations.

The Demographic and Health Surveys (DHS) program follows a different path; it highlights not pregnancy risk, but a women’s need for family planning in the near future. In the current definition, women are classified as “*having an unmet need for family planning*” if (a) their current pregnancy was unintended, (b) they are amenorrheic but their last birth was unintended, or (c) they are not amenorrheic, do not want a child in the next two years and are not using a method of contraception (neither traditional or modern). Unmet need for family planning thus encompasses more than the risk of unintended pregnancy. The discrepancy between these two measures (unmet need and non-susceptibility), although rather small, can be significant for women who have recently given birth, especially in Sub Saharan Africa, where postpartum abstinence and breastfeeding durations can be long. Using an older definition of “*unmet need*” (which includes amenorrheic women), Ross and Wilfrey (2001) reported that 73.8% of women in the one year postpartum period had an unmet need for family planning in the Sub Sahara African region. More recently (but still using the same method of calculation), Adeyemi et al. (2005) determined that 59% of their sample of Nigerian women had an unmet need for contraception at 9-10 month after delivery¹.

¹ An additional area of confusion in this area may be due to the “need for family planning for spacing” variable, another DHS concept. This measure pertains to the time between the last birth and the next one. Need for spacing (met and unmet) is often large, but does not correspond to the measure of unmet need during the one-year postpartum period, especially in Sub Saharan Africa, where birth intervals are long. For example, Gebreselassie et al. (2008) highlights in their summary that: “the risk of unwanted pregnancy is high during the year following the birth of a child, and many women have unmet need for contraception during this period.” However, supporting data on exposure to risk and pregnancy is calculated between the last birth and the time of the interview, that is, for several years after the last birth.

These findings of high unmet need contrast with the results of recent studies measuring exposure to the risk of unintended pregnancy after a birth. A prospective study conducted in the slums of Nairobi, Kenya (Ndugwa et al. 2010), showed that only 7.3% of all women-months were “at risk of an unintended pregnancy” in the first year after a birth; amenorrheic women were excluded from the pool of women at risk (Table 3, p. 347, own calculations). Similar to exposure to risk, unintended pregnancies are relatively rare in the one-year postpartum period. In the Nairobi study, only 71 pregnancies occurred during the 25,597 women-months of exposure under study (all within the first year after a birth). Another recent prospective study of women having had a delivery (Ganaba et al., 2010), conducted in several cities in Burkina Faso, showed similarly low pregnancy rates.

Altogether, family planning practice during the one year postpartum period in Sub-Saharan African countries does not seem to be characterized by high levels of unmet need; rather, most women and couples use traditional postpartum practices, which protect them, and some even then transition to contraception (Brown, 2007). Studying this transition is important, especially in settings where the uptake of contraception is still low, and where traditional postpartum practices are receding, like in urban West Africa. A full understanding of this transition from traditional protection to contraception will ultimately help to promote family planning in these settings, and reduce the number of closely spaced pregnancies, which have heavy consequences for vulnerable women and children.

In high-income countries, where breastfeeding durations are short, women start using contraception in the first few months postpartum. Family planning programmers initially attempted to apply this model to developing countries. The International Postpartum Family Planning Program, piloted in the 1960s and still in place in most developing countries, has “led to the general acceptance and widespread implementation of early provision of contraceptive information and services” during the postpartum period (Ross & Winfrey, p. 20). A number of voices critique this approach today. In contexts where resources are scarce, as much at the individual as at the governmental level, the idea of a “double protection” during the one-year period postpartum could be chastised as a waste of precious resources (Brown, 2007). An example of “redundant protection” can be found in Zimbabwe, one of the only African countries to exhibit early adoption of contraception after delivery despite long durations of postpartum insusceptibility. Other authors have pointed out that early contraceptive uptake after a birth can be counterproductive in contexts where disruption rates are high, leading to shorter, rather than longer, birth intervals (Becker & Ahmed, 2001).

In 1989, the family planning community accepted the “lactational amenorrhea method (LAM)” as a means of pregnancy prevention (through the Bellagio consensus statement): exclusive breastfeeding can serve as a contraceptive method during the first six months after a birth for amenorrheic women (Kennedy et al., 1989; Trussel & Santow, 1991). This method has been successfully piloted in several countries (Hight-Laukaran et al., 1997; WHO, 1999). However, there is no evidence to date that any national family planning program is effectively using it at a large scale in Sub Saharan Africa (Brown,

2007). Why most family planning programs in Sub Saharan Africa are failing to implement either of these two approaches (LAM or modern contraception) right after delivery remains unclear, and more research on this question is needed on the supply side.

There are also numerous questions lingering on the demand side. Recent studies show that women's contraceptive uptake is related to resumption of sexual activity in Peru and Indonesia (Becker and Ahmed, 2001), to the return of menses in Peru, Kenya, Indonesia and Dominican Republic (Gebreselassie et al., 2008) and to both in the slums of Nairobi (Ndugwa et al., 2010). However, the underlying individual-level mechanism of causality remains predominantly unexplored. In the case of urban West Africa, to what extent are women and couples purposefully relying on postpartum abstinence to avoid a pregnancy? Existing studies show that the practice is losing ground, especially in cities (Benefo, 1995; Dehne, 2003; Degrées-du-Lou, 2005). In such contexts of social change, are individuals and couples subjected to contradictory norms about postpartum abstinence? If this is the case, we hypothesize that these normative tensions are creating important obstacles to contraceptive use for women (Bajos et al., 2013). For example, women may have the intention to abstain for several months, and to later adopt a contraceptive method, but risk being unprotected when their husbands (who have a different vision of the appropriate duration of abstinence) convince them to resume sexual relations earlier. In regards to women's use of LAM, many questions remain as well. The return of menses is the traditional sign of the return to fertility in West Africa (Dehne, 2003): do urban women and couples still rely on this marker to adopt contraception? Do they know when amenorrhea is protective? To what extent do they follow messages about exclusive breastfeeding received at the health center?

In this article, we will investigate how the transition from traditional practices of postpartum pregnancy prevention (lactational amenorrhea and postpartum abstinence) to modern contraception is managed by family planning services on the one hand, and by women and men who have recently had a child on the other hand, in Ouagadougou, Burkina Faso. The urban West African setting is especially interesting to study problems on the supply side, because general service utilization is high. For example, in Ouagadougou, almost all women attend prenatal visits (98.5%), deliver in a health facility (97.4%), and have their child vaccinated (80.2% for all vaccines and 97.7% for BCG) (INSD, 2012). At the same time, contraceptive use remains low between births in urban Africa: only 27.3% of women have a satisfied need for family planning for spacing in Ouagadougou (versus 10.9% in Burkina Faso as a whole) (INSD, 2012). It is also fascinating to study the use of LAM in an urban Sub Saharan African setting, since the median duration of breastfeeding remains long despite urbanization (20.2 months in Ouagadougou versus 23.8 months in Burkina Faso as a whole) (INSD, 2012). The increased availability of weaning foods and a lack of information may constitute as obstacles to the implementation of this method. Finally, a West African city is the best place to study current changes in postpartum abstinence practices, and the impact of these changes on contraceptive uptake (the median duration of postpartum abstinence is 5.5 months in Ouagadougou and 7.7 months in Burkina Faso; the average is 11.5 months for the entire country) (INSD, 2012).

Materials and Methods

Observational study and semi-structured interviews

An observational study was conducted between April and June 2012 at seven facilities that offer family planning services in Ouagadougou, including Centre Médical avec Antenne chirurgicale (CMA) Paul VI, CMA Kossodo, Centre de Santé et de Promotion Sociale (CSPS) Secteur 21, CSPS Polesgo, the Centre Médical la Compassion, Marie Stoppes International (MSI), and Association Burkinabè pour le Bien-Être Familial (ABBEF). The first four facilities are public health facilities. The Centres de Santé et de Promotion Sociale (CSPS), or Centers of Health and Social Promotion, provide a minimum packet of services, including activities for preventative and curative care, as well as maternal and infant health, and Centres Médical avec Antenne Chirurgicale (CMA), or Central Medical Surgical Units, are the reference hospitals for their respective health districts. The Centre Médical la Compassion, MSI and ABBEF are non-governmental organizations that are based in Ouagadougou and offer inexpensive reproductive health services, including family planning, to the general population². An experienced Burkinabé female research assistant, contracted by the Institut Supérieur des Sciences de la Population (ISSP) at the University of Ouagadougou, observed each facility over the course of one week. The lead investigator introduced the research assistant to each facility via letter, where she was described as a researcher from the University studying maternal health³. The assistant spent several hours every day observing provider-client interactions and the overall functioning of the various sectors of maternal and child health services (immunization, delivery, family planning, etc.). During the observations, she initiated informal conversations with personnel to investigate family planning service delivery practices after a birth. The assistant wrote a structured observation report for each facility, mentioning the number of hours spent at each location, the number of staff-patient interactions observed and a number of service statistics.

The same assistant invited a convenience sample of 33 females and 12 males to participate in semi-structured interviews. One-on-one interviews were selected, instead of focus groups, to allow for in depth discussion of personal, potentially sensitive, information. All discussions were in Moré (the language of the Mossi, the main ethnic group in Ouagadougou), or in French, the national language. The women recruited for this study fulfilled the following criteria: they gave birth within the last 24 months and were residents of Ouagadougou. All female participants were recruited during their visit to one of the seven facilities. Similarly, men were selected to participate if their wives or partners had given birth in the last 24 months and were residents of Ouagadougou⁴. Since men rarely use maternal health services in Burkina Faso, and since clients did not agree

² MSI and ABBEF do not offer inpatient services (have no maternity wards), and are therefore excluded from the supply side of our analysis. However, women interviewed at these centers are included in the demand side of our analysis.

³ Except in the letter to the first health center, CMA Kossodo, which mentioned family planning explicitly, leading to biases and the replacement of the introduction word.

⁴ One man's wife was pregnant with their first child and in this case, we analyzed his intended practices.

to give out the phone numbers of their husbands, only 10 men were successfully recruited at the health facilities. Two more male interviews were conducted in the street in the neighborhoods close to the facilities. The questionnaire for men and woman was identical; however, men were unable to describe the family planning services received by their wife or partner. A more complete description of the sample can be found in the Appendix.

The semi-structured questionnaire was used to collect data on attitudes on contraception, knowledge of fertility and contraception, duration of sexual abstinence postpartum, breastfeeding practices and duration, duration of amenorrhea postpartum, attitudes on birth spacing and limiting, and past and current contraceptive use. Basic socio-demographic information was also collected. The interview guide was constructed in collaboration with the research assistant, who piloted it with several women and men in her own neighborhood, leading to adjustments in the questionnaire. Each interview lasted about 30 minutes. The interviews were conducted in private in a secluded area (for example, an empty room in a health facility). They were audiotaped, then translated and transcribed by several Burkinabé research assistants with experience in transcription at ISSP. Transcripts were compared with audio-files to check for accuracy.

Analysis of Data

The authors analyzed the transcripts by using thematic content analysis. The position and practices of each respondent was summarized in a thematic “portrait”, including key quotes. The information was then compiled in a table, including each respondent and their corresponding practices and attitudes. We then described the diversity of attitudes and practices, analyzing male and female responses separately. We also contrasted discourses of poorer, less educated respondents often born in rural areas with those of higher socio-economic and educational status often born and raised in the capital city. Finally, we related these findings to our observations of family planning services in the five health service delivery points with a maternity ward.

Ethics

The Institutional Review Boards of the Tulane University School of Public Health and Tropical Medicine in New Orleans, Louisiana, USA and the National Health Ethics Committee of Burkina Faso approved the human subject protocols of this research in agreement with the Helsinki Declaration. Each facility received a letter from the lead investigator requesting participation in the study, allowing the facility to either reject or accept further participation. The consent forms for participants in the semi-directive interviews indicated that questions would pertain to their attitudes towards, knowledge about, and experiences with birth spacing, family planning services postpartum, and childbearing. They were also informed that participation was voluntary, that the recorded information would remain confidential, and that participation could be terminated at any time without consequences. Participants received no incentives for participation in the study. Mock names were created for the analysis of the individual interviews, and no real names were retained. To preserve the anonymity of single health facilities, the information is presented without reference to particular centers.

Limitations

One important limitation of the study is selection bias, since participants were recruited at the health centers often for family planning services, or around the health centers. Therefore, we understand that our study is not representative of the population of Ouagadougou, since many women or couples in our sample are contraceptive users. However, some of these women were not using contraception, and many of those who adopted a method, did so long after their last birth. The sample remains thus adapted to explore the *diversity* of traditional postpartum practices and contraceptive trajectories after a delivery in Ouagadougou. Also, the research team did not achieve socio-demographic diversity in the male sample, which contains only few educated or Ouagadougou born men. The recruitment procedure (at the health center or in their vicinity) did not help to retain upper class men. However, we found the answers of men to be very similar to those reported by the women, so our conclusions can be deemed valid even with the incompleteness of the male sample.

Results

Post partum Family Planning Service Provision in Ouagadougou

In theory, women should have several opportunities to hear about and obtain family planning services around the time of a delivery: prenatal visits, delivery, the sixth day control visit, the sixth week control visit (scheduled 42 or 45 days postpartum), or weighing consultations (“consultation du nourrisson sain”) and vaccinations. Our observational reports indicate that family planning is primarily discussed and prescribed at the 45th day control visit. Nurses did not routinely discuss family planning during the observed prenatal visits, the post-delivery consultations preceding discharge, vaccination visits or weighing consultations. Health personnel are supposed to regularly provide a plethora of health information, on maternal and infant health and family planning, to women while they are waiting for various services. However, we witnessed such discussion only on vaccination and nutrition during the observation period. Despite this, we observed that the health staff often invites women to adopt a contraceptive method during the control visit. For example, Safiatou (31, secondary level of education) explains that she received information about family planning at the control visit: “Q: After your delivery, did you come to the 45th day visit? R: Yes, I came. [...] Q: Did they mention birth spacing? R: Yes, yes, they did. Q: What did they say on the subject? R: They advised to reduce births to improve health and this will allow us to better care for our children. Otherwise to have a lot of children very close together, their care becomes more difficult.”

Although the 45th day control visit is *the* time, as health staff confirmed, when postpartum contraception is supposed to be delivered in the observed health facilities, women rarely decide to adopt a method at this time, for two reasons. First, few women actually attend the visit, less than half in our health service friendly sample. The service statistics compiled from the five centers indicated that only between 4% and 33% of the women that delivered 45 days earlier attended the control visit. The health staff we talked to all acknowledged that low attendance to this visit was a problem. Some women did not come to the visit because they failed to receive an appointment, but many more did not

understand its importance. The visit is presented (at delivery) as a mere health check-up, and many women forget or overlook it because they feel healthy six weeks postpartum. Women who do not attend the control visit often miss their chance to receive a family planning message from a health worker at all, as reported by one respondent who said: “Many women told me that they already benefited from the advice of health workers on using, but I never had that chance” (Nicole, 29, primary level). She missed her control visit to attend a funeral and claims she couldn’t go later because “when you come to the health center after that set date, they (health workers) cause problems for you.”

The select group of women in the sample who actually did attend the visit rarely reported leaving it with a method. Actually, they had usually not resumed sexual relations by this time, and were not planning on doing so for some time. Therefore, they were not ready to start a method. Some women (with more than one child), already knew the purpose of the visit (family planning), and did not attend it for that very reason, since they intended to adopt contraception later. The few female respondents who adopted a contraceptive method at the control visit did not have the intention to abstain postpartum. One respondent, who was prescribed pills at a former control visit after a previous birth, explains this well: “There are individuals who cannot wait for more than two months to have sex, therefore if you come for the 45th day and you start to use your method [at that time], [it’s good]. By the time there is a need to have sexual relations, it (contraception) will already be done” (Sarata, 36, no education).

Most women in the sample visited the health center for family planning of their own volition after the control visit date. They went directly to a section of the maternity center reserved for the provision of contraception (the “family planning” unit), where women receive referrals from all parts of the maternity center. Our observations show that women face key barriers to method access at the family planning unit during the extended postpartum period. First, if a woman is still amenorrheic after the 45th day, health workers require her to take a pregnancy test, which costs 1200 CFA (\$2.37). This is a significant amount of money for poor women (a month of subsidized oral contraceptive pills costs 100 CFA, or \$0.20, in comparison), as indicated by one woman who did not attend the control visit: “Q: When was the first time that nurses talked to you about contraception? During pregnancy or after? R: In the neighborhoods, it is talked about and at the hospital also, even during the weighings it is talked about. [...] Q: Therefore, it was after the 42nd day following your delivery that they talked to you about it? R: Yes. [...] During conversations, [...] it is said that there are tests to do before doing [family] planning. Q: So, if you haven’t seen your period yet, you have to do tests in order to be able to do contraception? R: Yes. Q: But why did you wait before your period returned before coming [to the health center]? R: It’s expensive to do the urine test” (Farida, 21, primary school). One experienced respondent (Florence, 30, secondary) decided to have the Norplant inserted at the control visit just so she wouldn’t have to pay for a pregnancy test later. Some health workers prescribe oral contraceptive pills⁵ to accelerate the return of

⁵ Since the majority of women breastfeed for a long time, most women using the pill during the postpartum period are also breastfeeding their child. The array of methods subsidized by the national government includes a progestogen-only pill compatible with breastfeeding. During our observation, we witnessed that only normal pills were prescribed in one health center, because of a stock-out of progestogen-only pills.

menses (after a negative pregnancy test) before prescribing another method (like the injection, which is popular in the study area). Other health workers simply ask women to return when they are no longer amenorrheic, without providing information about how to prevent pregnancy in the interim. For example, when one woman was asked why she had unprotected sex, still amenorrheic, she said: “It’s because they (health staff) said that you cannot use [contraception] without having your period” (Farida, 21, primary school).

Altogether, the current protocol in Burkina Faso is not conducive to contraceptive uptake after deliveries, because the current timing of the “family planning” control visit is too early for most women. A visit at 42 or 45 days postpartum is only appropriate for those who resume sexual relations shortly after birth, and most women in our sample waited at least a few months. We observed that no steps were taken to motivate these women to come to the health center later for family planning services, nor to facilitate their access to contraception while amenorrheic. Moreover, women’s trajectories during the postpartum period are diverse; they would seriously benefit from a personalized plan. No female participant reported that a health staff member had assisted her during prenatal visits, delivery, or post-delivery visits (except the family planning control visit) to establish a plan to prevent pregnancy during the postpartum period.

Perceptions and Practices of the Lactational Amenorrhea Method (LAM)

The Lactational Amenorrhea Method (LAM) is officially accepted as a contraceptive method in Burkina Faso. During facility observations, we found nurses to be very well informed of this method, primarily because it is a part of their training. However, we observed that the health staff never discussed the contraceptive effect of exclusive breastfeeding to mothers of infants. Nurses stress the importance of breastfeeding exclusively for six months to mothers after delivery and at weighing consultations (especially at the two month weighing visit), but only for nutritional purposes. We should also note that during our observations, the health staff did not promote *any* method of contraception, being it LAM or other official method. Nurses simply talked about the virtues of birth spacing, and referred interested women to the family planning unit of the maternity center for details. During visits at the family planning units (in the five health centers with maternities), health personnel never explained the range of methods available to clients. Nurses started the consultation by asking the woman: “What method do you want?” and the consultation continued from there.

In our female sample, there was a general recognition of the positive effects of exclusively breastfeeding one’s infant for at least six months. This recognition was based on their understanding of the nutritional value of breast milk for their infants, instead of the potential for protection against pregnancy. Women in the sample generally respected the breastfeeding advice they received from nurses, yet most introduced weaning food earlier than six months. These respondents reported that they began providing water, baby food, and/or milk substitutes between two to five months, and two respondents started providing substitutes (or formula) immediately postpartum because they were not producing enough breast milk. Despite the non-marginal practice of exclusive breastfeeding for the first six months, the vast majority of male and female respondents

were completely unaware that this practice can also serve as a method of contraception. Only four women in the sample were knowledgeable about this method.

Almost all female respondents understood that they were still susceptible if amenorrheic; they stressed the risk of pregnancy before the return of menses, but never reported an understanding of the protective effect of amenorrhea paired with exclusive breastfeeding during the first six months postpartum. On the other hand, all male participants believed that women are not susceptible if they are still amenorrheic. The discrepancy between male and female beliefs on this topic (one of the few we noted in this study) indicates that this understanding is new among women, most likely due to increased coverage on the topic by health personnel. Health staff discusses susceptibility and the benefits of breastfeeding for nutritional purposes; however, LAM is rarely discussed at any point of contact.

Perceptions and Practices of Post-partum Abstinence

About half of the female participants reported that they resumed sexual relations between one to four months postpartum. Eight respondents had not resumed sexual relations at the time of the interview, while another eight had sustained sexual abstinence for at least eight months. The longest reported duration of postpartum abstinence among the female respondents was twenty-four months. Timing at first sexual intercourse postpartum was noticeably later in the male sample, from six to fifteen months, in comparison to the females, most likely because the men were of lower socioeconomic status.

The customary view of postpartum abstinence in Burkina Faso is that sex after a birth is shameful, close pregnancies are bad for the child's health (they "break the baby's legs"), and sperm spoils the breast milk and causes the child to have diarrhea (Bonnet, 1987; Ouedraogo & Ouedraogo, 1997). Strict adherence to this attitude was rarely expressed in the female sample, and never expressed in the male sample, although there were quite a few traces of these ancient beliefs. For example, one female respondent indicated that sexual relations would hinder the growth of her twins, presumably by spoiling her milk, although she did not fully understand the custom to explain her reasoning: "Q: This is to prevent pregnancy that you are afraid to have sexual relations with your husband then? R: No, it's not just that! It is not fear to have another pregnancy that causes me not to have relations with my husband since my delivery. [...] This is so my children can gain weight. Q: This would therefore affect the babies, if I understand you? R: Yes, this would hurt the babies" (Djeneba, 24, primary school). One woman waited for one year before resuming sex because she did not want her baby to get sick: "Q: Why did you wait one year before having sexual relations? R: Me, I was not in a hurry. [...] His father, when you tell him to protect himself [with a condom], he doesn't want to protect himself, so me, I'm afraid that I'll start again soon, [and] soon I'll get pregnant again. [...] Because my mom told me; my mom made me afraid; my mom told me that if I enjoy [sex], my child will have diarrhea and what not!" (Madina, 22, primary school). Altogether, eight women in the sample, predominantly rural born and poorly educated, still found prolonged postpartum abstinence to be very important and believed the act of sexual intercourse could hurt their infant's health. These respondents abstained from sexual relations postpartum for a lengthy period, from eight to 12 months, although the

traditional norm is to abstain for up to two years. These women also never view sexual relations in the postpartum period as shameful.

The majority of female and male respondents found it unnecessary to abstain for a lengthy period, given that contraception was an alternative option. These views sometimes paralleled lingering attachments to old customs, as in the case of one female respondent who said: “If the gentleman really wants to sleep with his wife quickly [...] maybe the day of the control for the child (visit), he can say to his wife to go do [contraception]...certain children don’t support it, certain children vomit when women do [sexual relations]! » (Armelle, 30, primary school). In some cases, condoms were seen as a good solution to accommodate the desire to resume sexual relations quickly after a birth, and to avoid “spoiling the milk”. Those who fit in this category were predominantly more educated and urban born in the female sample (and just more educated in the male sample). Many female respondents in this group expressed concerns that abstinence could lead their husbands to become unfaithful and cause marital conflict. For example, one respondent said: “Well, I knew this would happen by the end because through our discussions, he liked to say that when the child is still small, [men in similar cases] seek out women (commit adultery) while he assures you he will not. I started by saying [to my husband] that if this is the case, I’ll will go to get help (contraception)...” (Nicole, 29, primary school).

Despite the fact that the sample is mostly Muslim, only a few of the women and men had heard of the Koranic prescription of resuming sexual relations 40 days after birth, and even fewer used this argument to defend very early resumption of sexual intercourse. Most respondents wanted to wait at least a few months, even those who did not see the point in abstaining given contraceptive protection. One male respondent expressed this view well: “They say that 40 days after is good but me, I find that that’s too early. The baby is too little; his mother is not completely healed. If not, it’s each [man] and his wife; if you want to resume; there is no moment written in stone; it’s a question of agreement with your wife” (Nabyoure, 28, secondary school).

Inevitably, some respondents were in-between the two positions we described. The six women within this “in-between” group claimed that abstinence is unnecessary and ended up using contraception, but tended to abstain for a prolonged period of time postpartum, some for up to one year. The three males within this category also found abstinence to be unnecessary but were practicing prolonged periodic abstinence postpartum. Women often reported that their partner wanted to abstain for shorter periods than they intended. When asked if her husband decided to resume sexual relations (50 days after birth for this couple), one woman said: “It’s him who imposed [sexual relations] on me, it’s not me. I didn’t want to start quickly like that. The Mossi say that when the child is still little [it’s not good], so, I wanted to wait for when the child reached a minimum of two months so that the child doesn’t fall ill from illnesses...” (Florence, 30, secondary). In most cases, women accepted their husbands’ propositions for sex earlier than they would have liked, and without contraceptive protection. For example, one male respondent discussed his first sexual encounter postpartum as follows: “I know that I had a little too much beer to drink. I went out with my friends and we did some serious drinking. I dare not say that I

was drunk, but I was good. I don't remember how, but when I tried, she did not refuse me. After I slept and I don't know what happened. The next day, she made fun of me saying that I was really good (drunk)[...]. The next time, she insisted that I wear a condom, as well as the last time [we had sex]..." (Eric, 32, primary school).

Knowledge, Perceptions and Practices of Contraception

All participants knew of at least a few modern methods, and were particularly aware of oral contraceptive pills, the injectable, the implant, and male condoms. Although the respondents claimed to know of certain methods, they were often unclear on details, even of the methods they had used or were currently using. Only two respondents provided background information about traditional folk methods, while a handful of (predominantly more educated) women were aware of the Standard Days Method (SDM) or periodic abstinence. Some of those who claimed to be knowledgeable provided incorrect information on SDM when discussing their experiences with the method. Male participants were markedly less educated about family planning, although all were aware of at least a few modern methods.

The vast majority of men and women in the sample had positive views towards contraception. This positivity was expressed by one female participant who said, "With family planning, the woman can rest [for a bit] without having an undesired pregnancy. [...] it's a good thing, because if after giving birth, you do not do more than four months before getting yourself pregnant, that, that's not good. So, I would say that practice of family planning is a good thing" (Adjaratou, 25, secondary school). No respondents were against contraception for spacing, but some were opposed to the idea of limiting. For instance, when discussing birth limiting, one woman reports: "Our religion does not prohibit the act of planning, but there are limits. If this limit is reached, and you want to force it, you will encounter problems with God" (Alimatou, 40, no education). Despite positive attitudes, several male and female respondents reported fears of side effects of modern contraception no matter their level of education. These respondents most often reported fears that contraceptive use would lead to infertility. For example, one male participant stated: "Me, I learned that after contraceptive use, you can try to have a child in vain. You see, sometimes it brings more problems than good. Contraception is a good thing, but it should be used cautiously" (Eric, 32, primary school).

The majority of male and female respondents were protected⁶ at the time they resumed sexual intercourse postpartum; nevertheless, six women and one man were exposed to the risk of pregnancy after their last birth, often only for a short period. Although a few females successfully abstained until another child was desired, the majority of women in the sample started using contraception when sexual relations resumed. Most women started sexual relations before the return of their menses. Some women started using modern contraception while still amenorrheic. Others used condoms until a return of menses, at which time they switched to a modern method. However, we determined that a few women, who (a) were too poor to start contraception while amenorrheic, (b) were poorly informed, (c) had sex unexpectedly or (d) had uncooperative husbands,

⁶ We defined "protected" in a strict sense, including only those women who used a contraceptive method.

experienced a period of risk until their menses returned. While many respondents ended up using a modern method, a non-negligible amount of participants relied on condoms because they were either afraid of the side effects of medical methods or believed it helped to prevent contact between sperm and the woman. Condoms were sometimes used in tandem with periodic abstinence.

Conclusion

The purpose of our study was to describe how women transition after a birth from traditional postpartum pregnancy prevention practices to modern contraception in Ouagadougou. Data gathered on the provision of family planning services to pregnant women and mothers of small children show that the official Burkinabé program mixes two approaches, and that neither approach is fully implemented. The first approach: family planning services are to be provided at the 45th day control visit. However, health staff often does not express the importance of this visit: they do not mention that it serves as a visit for family planning. Also, most women abstain for a few months and find the timing of this visit to be premature. As a result, there is low attendance and even if they do attend, only a few women adopt contraception. The second approach: LAM is officially recognized as part of the method mix in the Burkinabé family planning program. However, nurses do not present this as a method when advocating for exclusive breastfeeding for 6 months. Health personnel at family planning service delivery points (where most women seek care of their own volition) do not provide information to women (or men) on the full range of available methods, inhibiting their contraceptive choice. As a result, women in Ouagadougou rarely practice this method or even recognize that they are using this method, although they may be doing so inadvertently while amenorrheic due to their awareness of the benefits of exclusive breastfeeding for their infant.

A new framework is necessary in order to integrate these two approaches, which are both useful given the diversity of demand in Ouagadougou. At delivery and during prenatal visits, women should be advised about LAM, and a family planning control visit should be scheduled for the 6th month postpartum (in accordance with WHO recommendations, 1998). The protocol for the 45th day visit should be maintained for women who are either unable or do not want to use LAM, although this method should be stressed during prenatal visits and at delivery. It should be mentioned that there is a serious problem on the service delivery side with contraceptive uptake by women who have not yet had a return of menses postpartum, and want a method after the 45th day control visit. Pregnancy tests should be subsidized, and health providers should be trained to handle such cases efficiently and equitably.

While part of the issue with contraceptive uptake postpartum lies on the supply side, other problems arise from normative tensions on the demand side. Women and men have varied and complex attitudes about postpartum abstinence, and couples may resume sexual relations earlier than intended, as many women indicated in our sample. Numerous norms on the topic co-exist in urban Burkina, as in other West African cities, leading to

method switching and the unexpected resumption of sexual relations postpartum. On the other hand, traditional practices of breastfeeding are well enforced by health personnel and are strictly followed. This congruence could be used as support for the acknowledgement and widespread proliferation of LAM as a postpartum contraceptive method among health providers and clients.

In conclusion, our study confirms that the vision of a massive unmet need for family planning in the postpartum period is erroneous for Sub Saharan Africa, because of an extended recourse to traditional preventive practices (postpartum abstinence and lactational amenorrhea). But our results also show that given the co-existence of the ancient and the new (Brown, 2007), the transition from traditional practices to modern contraception is accompanied by many (although often brief) episodes of risk taking, because neither individuals nor health systems are equipped to deal with this complexity and these contradictions (Bajos et al., 2013). Finally, our study shows that, if traditional practices of birth regulation are not sufficient to space births in this West African city today, medical modern contraception does not yet constitute as an appropriate answer in the eyes of all: fully accepted by most Ouagalese for spacing, modern contraception is still feared by many as long as desired family size is not yet achieved.

Appendix

A total of 33 women, all of reproductive age (15-49 years), were included in the analysis, reporting on 34 live birth events during the two years preceding the interviews. Three additional women were excluded from the study because they were not eligible, did not give birth in the two years preceding the survey. Two others were excluded because their interviews were incomplete. Eligible participants had between one to seven children and one to thirteen pregnancies. All female respondents were in union and two were in polygamous unions. Six women received no education while 14 had a primary school education and 11 had a secondary school education. One woman in the sample received a superior education and one was not asked her level of education. The female sample was also predominantly Muslim (45%), Mossi (67%), and lived in the formal settlements of Ouagadougou (45%, although one was not asked this question). Ten women were Protestant or Evangelical, eight were Catholic, and 15 were Muslim. Other ethnicities cited besides Mossi were Gourounsi (3), Bissa (1), Bobo (1), Bete (1) and Dagara (1). Although one woman was not asked and another did not report her age to deduce this information, 11 women were born in Ouagadougou. Several women (10) in the sample had emigrated from Cote d'Ivoire since birth, one female respondent from Ghana, and the rest from other predominantly rural areas of Burkina (10).

The sample includes 12 male respondents. The age range was 25-70 years, with four males less than thirty, four less than forty, and four greater than forty. The men had between one to nine children, the majority having between one to four children (9). Although one did not provide this information, two had no instruction, seven had a primary level of education and two reached a secondary level of education. The majority

of the male sample is Muslim Mossi. The majority also resided in formal neighborhoods; eight were migrants and three were from Ouagadougou, of those that responded.

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