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'The body is difficult': reproductive navigation through sociality and corporeality in rural Burundi

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ABSTRACT

The route from family planning intentions to practices is not linear, it is contingent on different social factors including the preferences of individuals and couples, their gendered positions and bargaining power, the wider political, economic and social context, and also physical and bodily circumstances. We used qualitative data collected in rural Burundi between 2013 and 2016 to explore how these diverse factors influence reproductive navigation in a context framed by uncertainty and changing social norms. We describe representations of bodily (pre)dispositions for fertility and reproduction, such as the 'natural' capacity for birth spacing or the bodily capacity to use 'natural' (having a regular cycle) and 'modern' methods (not having negative side effects) that contribute collectively to an understanding of 'the body is difficult'. We found that despite these bodily constraints, women enact embodied agency to ensure livelihoods and social status, thus framing their reproductive intentions and practices. In the context of Burundi where corporeality is key to gendered social belonging, family planning programmes fail to respond to the needs and concerns of women and their embodied reproductive experiences.

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Introduction

In autumn 2014, we met Emmeline for the first time, in a rural town of Burundi, Butare. She was 30 years old, married with two young children and she cultivated the family fields to ensure the subsistence of her household. She explained how she had started using the 'modern' forms of contraception promoted at her health facility:

> Emmeline: What made me think of modern contraception? It's because I saw that I was often ill, I was weak, I had poor health and issues in my body. So I thought of it. And also because each time I had a pregnancy, I didn't feel well, I had abdominal pain and I had to stop my everyday activities. So that's why I thought of coming to the health centre [to access contraception].

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When we met Emmeline again one year and a half later, she said:

Emmeline (E): After stopping the injections [because of the side effects they caused], I had a pregnancy

Joëlle (J): Was that pregnancy desired?

E: No …

J: Your first child was eight years old, didn't you want to have a second child then?

E: It was not time yet because of my poor health

Emmeline explained that after her first pregnancy that spontaneously aborted, she suffered from abdominal and back pain. She was treated for it, but her health problems resumed when she became pregnant again. After the successful birth, the health provider advised her to use 'modern' birth spacing methods. She chose the free injections offered at the health centre to avoid a pregnancy and gain time to recover her health. She experienced side effects (menorrhagia and abdominal pain) that she treated for a while using pills prescribed by her health provider. She abandoned the injections and became pregnant again, causing her health issues to return. The health provider advised her to go to a clinic for ultrasound tests. She decided not to undergo the examination because of the cost—her household was already struggling to meet basic needs. She explained she had no access to cash and had to ask her husband for health expenditure. She feared becoming a financial burden because of her ill health; and at the same time, she worried that her health problems would prevent her working in the fields, thereby becoming a social burden.

Emmeline's narrative illustrates how reproductive preferences, choices and practices are often not linear, can be influenced by different socioeconomic factors from the structural to the individual levels, and are contingent on *bodily realities* being framed by structural factors such as the gender division of labour, or access to socioeconomic livelihoods. Based on research in other contexts, scholars have shown that fertility and reproduction are best understood as 'socially-embedded processes' (Greenhalgh 1995, 17) within power dynamics situated in history and economics, in gender and culture, and in social norms (Ginsburg and Rapp 1991). Situated reproductive opportunities and constraints are framed by community structures, family systems, kinship networks and by 'available existing repertoires' (Bledsoe and Banja 2002) in the form of the gendered social scripts that shape individual expected, appropriate and desirable behaviour. Van der Sijpt has added the importance of corporeality—the material (physical) processes and activities of bodies, socially bound to systems of meaning (Grosz 1994)—to understanding reproductive navigation by exploring how bodies can experience 'reproductive mishaps' such as miscarriage or infertility (van der Sijpt 2014). As she summarises in her model, individual aspirations and the autonomous actions of women are situated, and contingent on the social environment (sociality) and on the material body (corporeality). Reproductive bodies are both social and material, and these two aspects are not distinct but continually interact, framing women's conceptualisations of reproductive health, and influencing their preferences and practices, as we have found in our research.

This study, conducted in rural Burundi, explored how women navigate their reproductive aspirations and actions within that context. In this paper, we show how women navigate different aspects of fertility and reproduction and make choices that are primarily driven by the intention to preserve their productive and reproductive bodies as their main social and material resource to ensure livelihood (through agricultural work) and social belonging (through maternity and sexuality). We use narratives to describe how women navigate different reproductive processes—marriage and their first pregnancy, birth spacing, and the utilisation of 'natural' and 'modern' methods of contraception—and we scrutinise the social and material values and representations that frame these embodied practices. Finally, we conclude by situating our findings within global reproductive health discourse, stressing that the assumed linearity between reproductive intentions and practices in family planning programming does not correspond to reality, and fails to respond to the needs and concerns of women and their embodied experiences.

Method

Empirical data presented for this article were collected through a longitudinal qualitative study conducted over a nine month period between 2013 and 2016 in four rural sites in Burundi: namely, Karusi and Nyabikere (Karusi province, central Burundi), and Rutana and Butare (Rutana province, South-East Burundi). To understand reproductive preferences and practices within context, we purposively sampled rural women of reproductive age, aiming to include married and cohabitating women, single mothers and single sexually active nulliparous women.

We conducted in-depth interviews using a biographical approach focused on sexual and reproductive health (SRH) events and interviewing participants two to three times over the four-year period. To understand the context and situate narratives, we conducted observations in everyday life spaces such as health centres, churches, schools, markets, cabarets and NGO community activities. We also conducted formal interviews and informal discussions with key informants (health authority representatives, traditional birth attendants, religious leaders and administrators). Fieldwork was conducted by the first author and local research assistants who were trained on SRH, confidentiality and ethical research. We trained four research assistants (3 female, 1 male), all with a university degree and living in the capital city Bujumbura. As a pair, we were perceived as outsiders, which sometimes stirred mistrust that we tried to mitigate by declaring that we were not promoting 'modern' methods of contraception and through our presence on repeated visits. At the same time, in the context of a general low level of interpersonal trust (Falisse, Masino, and Ngenzebuhoro 2018), not being members of the local community facilitated discussion on intimate topics, as we were told several times by participants.

Adapting to the tense socio-political situation, we abandoned the initial plan to conduct interviews and observations in participants' homes, as most expressed their reluctance to be seen hosting a foreigner, fearing negative reactions from neighbours and authorities. Instead, we opted for recruitment and interviews in health facilities, in spaces that allowed privacy for discussion. This limitation was partly mitigated by the

longitudinal design of the study, allowing discussing in-depth the individual and household situation and evolution across the period, and by positioning ourselves as non-health providers. We recruited most participants in the vaccination waiting area, briefly explaining the purpose of the research and providing guarantees of confidentiality and anonymity. After consent to participate, interviews were conducted in Kirundi and French, and were transcribed in French the same day, discussing content, translation and meanings with the research assistant. These discussions were then transcribed into memos.

In total, we conducted 39 interviews with 16 participants (13 women, 3 men, various parity, age range 18–37) followed over time, and 7 key informants. Transcripts and field notes were analysed using a constructivist grounded theory approach (Charmaz 2006). We used sensitising concepts to orient data collection, and in data analysis to support the development of thematic categories (Bowen 2006), namely the interplay between agency and structure, gendered social reproduction, and embodiment. Data were analysed after each field visit, allowing the construction of categories that were discussed within the broader research team, and further explored in the next field visit.

Analyses were first conducted by JS on rich transcripts using line-by-line initial coding looking for words, actions and processes, and included memo writing that attempted the contextualisation of reproductive events within the agency-structure interplay (Frohlich, Corin, and Potvin 2001). The rest of the data were analysed using focused coding, allowing the construction of categories that were then compared across narratives and scrutinised repeatedly for power, purpose and patterns. Finally, we developed a grounded theory based on the categories related to *bodily experiences* using memos and literature, presented in this paper. The names used in this article are pseudonyms.

Reproductive context and contingencies of rural Burundi

Karusi and Rutana provinces have very high population densities (respectively 376 and 214 hab/km^2), and the vast majority of the population lives on subsistence agriculture. It is estimated that more than 67% of Burundians live below the national poverty line, with a higher proportion doing so in rural areas (République du Burundi 2011, 24). Karusi province was strongly impacted during the civil war that devastated the country between 1993 and 2005, resulting in internally displaced persons camps that contain many widows and recomposed families. Rutana province offers a similar profile, with slightly better temporary economic opportunities as it is close to Tanzania and it hosts the national sugar factory.

Women are economically and legally dependent on men. Customary marital and inheritance laws position women under their husband's jurisdiction as subordinates with little to no avenue for social advancement and accumulation (Daley 2008, 53). Their access to land is conditioned by their belonging to a man, their father or husband. As described by Hakizimana (2002, 236), Burundi is a 'patriarchal society in which decision power belongs to husbands and their lineage, and women are reduced to the role of life reproducers, children carers and female children educators and

domestic and land workers. It is through maternity, ideally numerous, that women integrate their husband's clan', and gain social status. Socioeconomic organisation places women in charge of households' subsistence agriculture, while men 'seek money' through temporary jobs on construction sites or seasonal agricultural work in neighbouring Tanzania to provide for expenses such as school fees and equipment, health expenditure, and social events.

Current social changes in post-conflict Burundi are transforming gender and generational relationships, redefining women's social position and bargaining power within the household. Studying the social transition from youth to adulthood in Burundi, Berckmoes and White describe how 'structural problems such as land scarcity, climate change, population pressure and a rural economy that offers limited opportunities for non-agricultural income generation, stand in the way of successful youth "transitions" and impede clear scenarios for ways out' (2014, 200). The limited opportunities to build social status and ensure livelihoods identified by youth were marriage for girls, and migration for boys, but all shared a 'lack of adult support and guidance [showing] that the youth generation feel increasingly disconnected from their parental generation' (201). Land pressure also leads to children becoming a source of conflict due to the customary heritage law whereby all male children are attributed an equal share of land (Keenan 2015). Socioeconomic impoverishment and instability reduces the social protection of women as they are more likely to accept cohabitation (*gucikiza*) without formal marriage, leading to precarity because their access to land is not secured (Courtois 2016).

Largely supported by external donors, the government promotes family planning as a technical solution to socioeconomic and political problems (Schwarz, Manirakiza, and Merten 2021). The hegemonic discourse suggests that by controlling fertility and having fewer children, individuals, families and communities will improve their own situation economically, reduce the pressure on land, and contribute to the nation's stability. The fertility rate in Burundi was 5.5 children per women in 2016, and the prevalence of women in union using a 'modern' method of contraception was 22.9% (Ministère à la Présidence chargé de la Bonne Gouvernance et du Plan et al. 2017).

A variety of contraceptive methods[1] are promoted by the government and provided for free in health facilities. Health providers receive financial incentives for the distribution of 'modern' methods through a performance-based financial scheme. The Catholic Church, as well as the fast-growing evangelical churches, are opposed to the promotion and use of 'modern' contraception but have aligned themselves with government discourse on the need to reduce fertility and promote 'natural' methods such as standard-days method and periodic abstinence. In everyday life, access to contraceptives is limited, and the counselling quality is low. Only 29% of women using 'modern' contraception reported being informed about the potential side effects of the method or what to do if these occurred, or about other available methods (Ministère à la Présidence chargé de la Bonne Gouvernance et du Plan et al. 2017, 108). Side effects have been reported as a major barrier to taking up 'modern' methods of contraception (Schwarz et al. 2019). Documentation on the use of traditional medicine for infertility and reproduction in Burundi is scarce but shows that nowadays healers mostly work in secrecy and have multiple practices 'such as herbalism,

divination-herbalism (*abapfumu*), rain-making (*abavurati*), sorcery (*abarozi*) and/or Christian syncretism' (Falisse, Masino, and Ngenzebuhoro 2018, 487). Recent research has shown that their range of action and methods have changed over time, adapting to socio-political trends, for instance by providing psychosocial support and enhancing community cohesion in the post-conflict era (Falisse, Masino, and Ngenzebuhoro 2018; Ventevogel et al. 2018; Cazenave-Piarrot 2017). These interconnected contextual structural factors set the frame for the embodied actions of rural women analysed in this article.

Findings and discussion

Discussing family planning strategies and preferences with women in rural areas of Burundi, the phrase 'the body is difficult' (*umubiri uragoye*) or 'it [depends on] one's body' (*n'umubiri w'umuntu*) emerged frequently, designating a variety of different situations. We explore these descriptions of the body in relation to fertility and reproduction—through marriage and first pregnancy, birth spacing, and the utilisation of 'natural' and 'modern' methods of birth control—constructing our argument on the pertinence of these bodily experiences in relation to social contingencies in understanding reproductive navigation.

(In)fertility: unpredictable capacity and strategic timing

As in many other contexts, successful fertility is a pre-condition for social adulthood. By becoming mothers or fathers, individuals 'move to the next stage' (*narunguruje*) and gain adult social status. The first pregnancy—estimated to occur at a median age of 21.3 years in rural areas (Ministère à la Présidence chargé de la Bonne Gouvernance et du Plan et al. 2017)—however should be socially timed. For younger generations, pregnancy is an event that opens up to two opposite outcomes: it could trigger marriage or cohabitation; or it could lead to the status of single mother, jeopardising chances for marriage or cohabitation in the future. Narratives from single mothers showed how they had hoped the pregnancy would facilitate concretising a relationship into marriage, but how instead it could lead to their partner abandoning them as single mothers with very little chance of finding another man willing to marry them. Single mothers thus became a burden to their own family, with limited perspectives for *narunguruje*.

Often expressed in terms of God's willingness to gift women with children, or serendipity, we found that fertility was strongly associated with a perception of bodily capacity. Fertility was considered an unknown until women had their first child, as expressed by Juliette, aged 37 from Nyabikere, who had five children and hoped for one more:

> Joëlle: Before your marriage, had you dreamed of having six children?
>
> Juliette: I couldn't have thought of it before knowing I could have children!

The unknown about fertility capacity was also described by young, nulliparous women who considered that 'modern' contraceptive methods were not suited for

them, as they should not modify their bodily capacity for fertility using 'artificial methods' before having tested their capacity to bear children naturally.

Primary infertility was feared by women, as married women without children were socially perceived as 'worthless'. Hakizimana described that 'downgrading, offensive and humiliating terms designate sterile women. They are considered children's enemies, poisoners and savage beasts. They are repudiated because they do not fulfil their primary role in households, namely the continuation of the paternal lineage through numerous births, preferably boys' (Hakizimana 2002, 236). Data on infertility in Burundi is scarce; the 2008 census reported that 6% of women aged 45–49 years were nulliparous (Ministère de l'Intérieur 2011). Secondary infertility was perceived as less stigmatising and was explained by many as being the consequence of widespread malnutrition and subsequent anaemia and poor health. Yet, many other factors could explain secondary infertility, as expressed by Clémentine, aged 35 from Butare, who had had long intervals between her pregnancies:

> Joëlle: So, between your second and third pregnancy, many years have gone [9 years], how did that happen?
>
> Clémentine: That it takes time is normal. There are women who wait and wait until the end! Some need more time to get pregnant, that's how they are!
>
> J: Were you worried because so many years had gone?
>
> C: Worried to have problems because it took me so long? No, I had no problems. Only, even before that, I had issues getting pregnant because I lack blood. […] But how not to worry? The body is difficult. You think what happened? Have I finished [reached menopause]? And then, feeling I was pregnant, I was surprised! Or you think perhaps I've been poisoned? You think of many things …

This narrative illustrates how women had different explanations for such 'difficulties of the body'. They included inner-bodily causes (lack of blood, menopause), outer influences that entered and changed the body (witchcraft, illnesses like malaria), or both.

As several participants explained, individuals could act on their own bodies, or someone else's, by hiring a healer (*umupfumu* or *umurozi)*. We found reports of 'evil' healers (*umurozi*) who could cast a spell of infertility on someone else. Participants however explained that 'good' healers (*umupfumu*) could help women to 'temporarily' abort, by 'putting the pregnancy on hold' in the womb. This action allowed pregnant women to gain time to secure their social situation (find a suitable partner, mostly), and then later the *umupfumu* would 'release the pregnancy' in their body.

Birth spacing: a 'natural' bodily capacity

For couples who married, social pressure was placed on the woman for a first birth that should come rapidly to confirm fertility and ensure lineage. After the first birth, spacing for the next pregnancy was highly valued. The ideal interval of about three years allowed the newborn to be cared for by his or her preceding sibling while the mother was occupied with her daily domestic or farming work.[2] Data show that the majority of women (82%) in Burundi space their births by at least 24 months, with no differences across education level or economic well-being (Ministère à la Présidence

chargé de la Bonne Gouvernance et du Plan et al. 2017). Furthermore, spaced births were associated with a notion of disciplined sexuality and family organisation, as noted by Hakizimana: 'High fertility was traditionally valued, but unspaced births was negatively associated with "uncontrolled" and irresponsible sexuality, designated by a specific Kirundi term *intahekana*' (2002). Donatienne, aged 27 from Nyabikere, explained how her unspaced pregnancies caused her shame:

> When the first child was nine months old, I faced many problems because I already had a three-month pregnancy. Imagine! It really traumatised me. [...] Having a pregnancy when your first born is nine months old, it means you have to wean him. You understand it's problematic, as a woman your life becomes difficult. Even if your family is self-sustaining, you can't have a good life. Luckily my husband took care of me and helped me take care of the family I already had. He would watch our firstborn, fetch water and wood, while I was pregnant. I suffered a lot. He was accomplishing the chores a woman must bear!

Donatienne's shame was associated to her not being able to fulfil her gender-assigned tasks, and she subsequently actively sought a family planning method to avoid facing such a situation again.

While birth spacing was socially valued, it was linked to health values that women expressed with regards to mother and child health. For example, Emmeline in the introduction provided a health rationale for birth spacing. Allowing her reproductive body to regain strength between pregnancies ensured the fitness of her productive body for everyday life activities, and better health for her children. This was also explained by other participants, such as 22-year-old Martine from Butare:

> The advantage with spaced births is that you can have children that grow and you have a good health, instead of always carrying successive pregnancies, feeling ill in your body and having poor health that impacts your [socioeconomic] development. With birth spacing, you can be strong and develop your household situation, and your child can grow well.

Birth spacing was therefore valued for social and health reasons. Yet similar to fertility capacity, the capacity for birth spacing was often perceived as a 'natural' bodily given, that was unpredictable. As one's natural bodily capacity to space births could not be predicted, it therefore had to be tested, often causing mishaps of unspaced births. If natural birth spacing failed, after testing for it, then women took action by seeking a family planning method. They turned either to the 'natural methods' taught in Church, or to the 'modern methods' promoted by healthcare providers. It was not personal values and preferences only that drove the decision on which method to use; rather, decision was influenced by a contingent interplay between sociality and corporeality.

'Natural methods': the need to have a regular body

Fertility awareness-based methods—mostly standard days method or cervical mucus method—are promoted in church where they are taught to married couples, and in schools. They were valued by most participants because they were natural and non-invasive. However, they required women to have a regular cycle and be able to count cycle days. The main message given about these methods was that 'you have to be

regular' with menstruation cycles. Being regular was perceived as a naturally given capacity that was not equally distributed in women, as expressed by Gerald, a 24 year old student from Karusi:

> In our biology class, we learned to count menstrual cycle days, the ovulation date, the fecund period in women, and the period during which you can have sexual intercourse without conceiving. But it all depends on the girl, if she is regular or not.

Being irregular was presented and perceived as an irremediable barrier to using fertility awareness-based methods, as expressed by Ophélie, a 24 year old single mother from Karusi, who had no strategy to avoid another pregnancy:

> Joëlle: Would you like to learn about fertile and infertile periods in the cycle?
>
> Ophélie: Well … I hear others say that some are regular, and others irregular. So … if you have irregular menstrual periods, then you can't calculate. […] And I know that I am irregular, because they say that those who are regular have their periods on the same day every month

Not having the 'right body'—a regular one—excluded women from accessing these methods. For those with regular cycles, 'natural' methods often appeared challenging because they required capacity to calculate and monitor cycle days and sexual discipline to observe periodic abstinence. Among participants using such methods, we found that it was often men who calculated the cycle days of their partner, and women explained this in terms of a perceived higher capacity of men to do it, as in the case of Kristella, a 24-year-old nulliparous, non-married woman from Karusi:

> Joëlle: Do you know how to calculate your cycle?
>
> Kristella: I don't. My boyfriend does it. I've been taught in [community] sessions about these calculations and I've asked many questions, but it remains difficult for me to understand and know them

Women however also contributed to the use of fertility awareness-based methods by building knowledge and awareness of their bodily signs of fertility, which they explained with pride in interviews. They described their capacity to 'feel their bodies' and identify signs such as the ovulation period, as explained by Delphine, a 34-year-old mother of two from Nyabikere:

> Joëlle: And these natural methods work well for you?
>
> Delphine: Yes, they work well, and it's the only method I've ever used! […] but it necessitates great attention and a particular mastering
>
> J: With your technique, you verify each day at the same time?
>
> D: No. When secretions start, I can feel it, and it indicates that the fertile period arrives. That's when I wash my hands and touch myself to confirm the situation.
>
> J: What is the signal that tells you that you need to check?
>
> D: I know because I'm familiar with it, now. It's like when you're about to have your menstruations, you know. Even if menstruations arrive at night, you can already feel it during the day. It's the same for this fertile period. Even if I'm in the fields working, I go there with soap and clear water, and when I feel the situation, I wash my hands and verify, and I check the time because this period can last between 12 and 24 hours. Yes, I even know the life span of an ovule!

Finally, the utilisation of 'natural' methods required disciplined behaviour to observe abstinence over the fertile period. Observing abstinence was mostly perceived as a male role. The sexuality of men was described as determined by irrepressible and a 'natural' sexual desire that could hardly be contained, as explained by Georgina, a 52-year-old traditional birth attendant from Gihogazi:

> [Being faithful] all depends on a man and his habits. This habit, you can't take it off a man. They walk with it. For example, this woman's husband had the habit of having sexual relations elsewhere because even the children he had outside [of marriage] where from different women.

At the same time, men's capacity to enact or tame their 'natural' needs was socially valued. In fact, it was often men who were socially responsible for sexuality, reproduction and family organisation, as illustrated in the narrative of Donatienne:

> There are fertile periods, that period is when you have a lot of water in your vagina. You have to be abstinent during this period, and my husband really helps me. Because I believe that it all depends on men's decisions: if he doesn't abstain from me, how could I space my births?

Attempting to negotiate sex, reproduction and family organisation was traditionally limited for women and often considered transgressive (Hakizimana 2002). Such negotiation was often contingent on the social position of women. Clémentine, who married at age 14 and lived with her husband and in-laws described how she strategically enacted her body—and sexuality—to secure her social position, anticipating potential problems her resistance could cause:

> Clémentine: Because we are legally married, if my husband brings a woman or a child, I will be supported by the authorities [as the legitimate wife]
>
> Joëlle: Is there something you can do to avoid the situation?
>
> C: To avoid this, I must do everything for my husband. It necessitates communication also, and I must obey my husband, avoid committing any fault because that could be a reason for him to bring another wife.
>
> J: What type of fault do you have to avoid?
>
> C: Mostly what causes polygamy. In my case, my husband works to pay his beer, and when he returns at night without bringing anything for the household, when he comes into our bed if he invites me to have sex, I can't tell him I'm unhappy and I'm hungry. Rather, I have to accept, otherwise that can bring further problems. If I refuse, that could push him to get another woman. These are the types of fault that I avoid.
>
> J: It means that if you don't want to have sex, you'll do it anyway to avoid him going elsewhere?
>
> C: Yes, that's the only way, I must accept.

Younger participants' narratives revealed how gender roles in sexuality and reproduction are changing, in a context of men's diminished capacity to perform their expected masculine roles and responsibilities. We found that young women could strategically negotiate sex or the use of fertility-control methods, for example. This was illustrated by the story of Kristella, single and nulliparous, who explained how, after one year of a relationship including sexual relations, she imposed abstinence to her

boyfriend. She wanted to test his willingness to make their relationship official by organising marriage. She sadly but proudly explained a year later how her strategy enabled her to find out that he was not serious about their relationship, and how she had avoided a pregnancy that would have been problematic in her social situation.

To conclude, we hypothesise that 'natural' methods are highly valued because they serve a double purpose: they offer birth control, and they enhance couple collaboration and cohesion around sexuality and reproduction. The capacity of men to discipline their bodily needs and desire is promoted as virtuous and is socially valued, as expressed in the narrative of Donatienne who took pride in her successful couple cooperation over 'natural' methods. However, the social cohesion promoted by the Church is founded on specific gender roles concerning sexuality and reproduction that are currently being challenged by ongoing poverty-induced social changes.

'Modern methods': a risky choice for the body

We found a widespread discourse around 'modern' contraceptives which stressed the negative side-effects they were purported to provoke in bodies, and the socioeconomic consequences of *failed bodies*. As we have developed elsewhere, physical side-effects caused by hormonal contraceptives—mostly menorrhagia and subsequent fatigue and anaemia—were problematic for some rural working women (Schwarz et al. 2019). On explaining the unpredictable occurrence of side-effects, most narratives expressed the perception that 'modern' methods do not suite all bodies: 'it depends on one's body! It can happen that you don't get side-effects, while others have them', as expressed by Christine, aged 18 from Karusi. The perception here was not so much that hormonal methods were harmful, but rather that the reaction they triggered varied across bodies:

> Joëlle: Aren't you afraid of these side-effects you've heard people talk about?
>
> Donatienne: (Laugh) you know, we say it depends on the person, and side-effects don't appear in everyone, that's why I couldn't tell [these methods] are good or bad.

Success in using 'modern' methods depends on one's bodily capacity—having the right body—to react successfully to the outer interference of contraception. Women openly expressed their fear—and the perceived risk—of modifying their inner materiality by ingesting, injecting or inserting external *materia medica* (Whyte, van der Geest, and Hardon 2002). It was the bodily capacity and reaction to the medicine that was unknown and created concern, rather than a perception that methods were harmful.

When interviewing women who used 'modern' methods, we asked how they chose their contraceptive. Emmeline explained that she chose the injection because she had already used injections for the treatment of illnesses (referring to malaria) and therefore trusted them more than other methods:

> Joëlle: Why did you choose the injection, why did you prefer this method?
>
> Emmeline: It's because I was often ill before, and at the health facility they always gave me injections for treatment and they made me feel better. That's why I thought I should get an injection (laughing)!

Participants explained that there were no ways to predict the potential side-effects of 'modern' methods on their bodies and one thus had to test the methods to see their effect. Such testing was however perceived as risky: first, it only allowed testing immediate effects and not long-term ones; and second, some effects were remediable while others were not and damaged the body more permanently. We have described elsewhere how the health system mostly trivialised the issue of side-effects and thus failed to acknowledge and respond to the everyday concerns and lived experiences of women (Schwarz et al. 2019).

Ultimately, we found that testing effects on the body was a physical and social risk many women were not willing or able to take contingent on their socioeconomic situation, as they needed functional productive and reproductive bodies to sustain a livelihood and social belonging. Many women also expressed the fear that in the case of physical side-effects their husband would leave them or take another wife.

Some limitations

With regards to fertility and reproduction, Burundi is specific because of its high population density and subsequent land pressure, whereby the value of numerous children has (partly) shifted from being an asset to becoming a liability, as has also been found in Rwanda (Farmer et al. 2015) but not in neighbouring DRC where children are still perceived as 'une richesse' (Dumbaugh et al. 2019). While Burundi has changed since the time of the study, we believe our findings are still valid today: land reforms have not taken place; family planning programmes remain strongly supported by external agencies; and although the evangelical churches have gained influence, their position on contraceptives is similar to that of the Catholic Church. Lastly, this research focused on reproductive practices in women and more research is needed to explore (re)configurations of masculinity in relation to sexuality and reproduction, and social (re)organisation.

Concluding remarks

This research has shown that the interplay between *corporeality* and *sociality* is central to reproductive navigation in rural Burundi, and that reproductive decisions and practices should be understood as embodied actions. Social conditions and power dynamics shape embodied actions and meanings while, at the same time, bodily capacity drives social position and gender power relations.

In a context where the reproduction of gendered social organisation is in crisis (Courtois 2016; Berckmoes and White 2014), and where women and men struggle to ensure livelihoods and social belonging, the material body is an important resource for women and its preservation is essential. This frames perceptions of risk as socially assessed by women, for example with regards to the use of 'modern' contraceptives. The perceived risk associated with hormonal methods in rural Burundi is useful in understanding the limited uptake of 'modern' contraceptives. In fact, in global and national family planning programmes, low uptake is often explained by a lack of information or by cultural and religious beliefs, trivialising the reality of contraceptives' side

effects. We found that the family planning programmes offered by the Catholic Church were more appealing to participants because they were grounded in social and family organisation. However, they partly failed by excluding women with 'irregular bodies'.

Our findings align with the reproductive navigation model proposed by van der Sijpt that frames reproductive decision-making as a process that is not universalist and linear, but is contingent on complex social, economic and political dynamics, as well as on bodily matters (2014). Reproductive health policies and programming in the Global South, largely pushing for uptake of 'modern' methods and supported by external donors, present a rationale based on individual autonomous and empowering decisions and on linearity between reproductive intentions and behaviour. International programmes such as FP2020[3] establish population targets such as the 'unmet need for contraception', calculating the gap between women's fertility intentions and their contraceptive use reported in surveys, that is to be filled by an increase in 'modern contraceptive prevalence rate' (Hendrixson 2019). As we have shown, there are numerous pathways and contingencies that influence reproductive navigation from intentions to practices. Furthermore, as highlighted by Adjamagbo and Locoh (2015), it is too simple to assume that by using 'modern' contraceptives, women will meet their needs and empower themselves. The importance of bodily matters—not expected at the onset of this research—is a finding that adds to the framework for understanding reproductive intentions and practices, advanced by van der Sijp. With respect to the argument that 'modern' contraception empowers women, we did not find that rural women saw their economic or symbolic bargaining power being enhanced by control over their fertility.

As in other regions, we have highlighted how current transformations of social organisation and power—particularly in relation to gender and generation—translate into the coexistence of diverse reproductive regimes (Agadjanian 2005), such as single mothers, smaller families, couples using behavioural 'natural' methods, and couples using 'modern' methods. Not all participants assessed their trajectories and situations as positive or desired, some were in fact very constrained, but our aim has been to reveal strategies and embodied adaptive behaviours that women enacted within their limited spaces of power. In this study, women cautiously assessed their (limited) reproductive options and made choices that aimed at preserving their main resource: namely, their productive and reproductive body. Besides giving voice to women concerning their role in social organisation, revealing the challenges that exist in Burundi today with respect to social organisation and social reproduction provides insight for research and policy development in other fields, such as peace building and economic and agricultural development.

Finally, this research was grounded in the specific context of Burundi, framed by high population density and issues related to land use and ownership, as well as by 'enduring and looming' socioeconomic crisis (Berckmoes 2017), that have contributed to maintaining very unequal gender roles and positions. Johnson-Hanks has described how 'under conditions of uncertainty applicable in contemporary Africa, effective social action is not based on the fulfilment of prior intentions but on judicious opportunism' (2005, 363) that she further describes as 'vital conjunctures'. As Courtois (2016) has shown in the case of female-headed households or Serwat (2019) with land reforms and decentralisation processes in Burundi, within observable changes in

gender reconfigurations women mostly suffer in current circumstances, opportunities are limited and gender inequalities in rights, roles and expectations remain pervasive.

Notes

1. Methods promoted included 'modern' methods of contraception (the contraceptive pill, injections, implants, intrauterine devices (IUD), the emergency pill, condoms and tubal ligation/vasectomy), and 'natural' methods of fertility regulation (lactational amenorrhea, symptom-thermal method, calendar method, withdrawal).
2. For a historical perspective on the reproductive economy regimes operating during colonial times, see Hunt (1990).
3. FP2020 is a global initiative where different actors (including governments, international organisations and private industry) jointly make political and financial commitments for FP promotion.

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Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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