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'Cleaning the womb': perspectives on fertility control and menstruation among students in Antananarivo, Madagascar

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ABSTRACT

This article discusses students' perspectives on fertility control, including induced abortion, in Antananarivo, Madagascar. The study draws on a total of nine weeks of ethnographic fieldwork conducted in 2016 and 2017. It argues that while the majority of the students do not refrain from premarital sex, they negotiate their desire for physical intimacy in accordance with the prevailing discourse of premarital abstinence among the Merina ethnic group in the central highlands. In this context, modern contraception, particularly hormonal birth control that could cause menstruation to cease, is considered highly problematic since it was believed capable of creating a 'blockage' of the reproductive system which in turn could lead to future infertility. Due to such cultural barriers, there is therefore low coverage and unmet need for contraception among Malagasy students in Antananarivo. Instead, they would rather rely heavily on traditional methods such as periodic abstinence or the calendar method. Moreover, due to the risk of unwanted pregnancy, menstruation is central to the moral control of own and other's sexual behaviour at both a personal and a collective level.

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Introduction

The Republic of Madagascar with its 587 square kilometres is the fourth largest island in the world. As of 2018, Madagascar's population was approximately 25 million, with 60 per cent of the population under the age of 25 (CIA 2019). With a total fertility rate of 440 per 100,000 live births, Madagascar has one of the most rapidly growing populations worldwide (Morris et al. 2014). However, it is also the 10th poorest country with 91 per cent of its inhabitants living on less than USD 2 per day (Morris et al. 2014), and state spending on health is a mere USD 21 per capita annually (Grant and Shoham 2018, 62). Madagascar's economic hardship has had a particularly serious impact on sexual and reproductive health. Faced with regular outbreaks of plague, cholera, drought and subsequent malnutrition, prioritisation of sexual and reproductive health within the public health sector has been very limited (Grant and Shoham 2018, 62).

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In addition to economic barriers to sexual and reproductive health in Madagascar, there are also legal, religious and cultural ones. Drawing on a total of nine weeks of ethnographic fieldwork between 2016 and 2017 primarily in Antananarivo (population of 1,391,433), Madagascar's capital city in the central highland plateau, in this article I discuss students' perspectives on premarital sex and fertility control, including induced abortion. Abortion in Madagascar is not only illegal, it is also criminalised.[1] As of May 24, 2016, the Women on Waves website stated that any person performing or attempting to perform an abortion on oneself or others in Madagascar, can be subjected to imprisonment and fines.

The purpose of the study was to investigate the interplay between policy and practice regarding girls and women's sexual and reproductive health rights with a focus on fertility control in Madagascar. While contraceptive uptake continues to remain low, according to the Malagasy Ministry of Health and Family Planning, approximately 75,000 clandestine abortions are carried out in the island every year, and complications due to unsafe abortions count for 60 per cent of maternal mortality rates (Gastineau and Rajaonarisoa 2010, 224).[2] Against this background, this article's objective is to discuss students' options and choices for fertility control in Antananarivo, and to unpack the cultural reasons for unmet needs for contraception.[3]

Sexual and reproductive health in Madagascar

At the time of the French occupation in 1895, Madagascar was a monarchy ruled under the Merina kingdom in the central highlands. The central high plateau with its capital city of Antananarivo was established as a place of central power in relation to the rest of the country, as was the region's dominant ethnic group the Merina (Randrianja and Ellis 2009).[4] A strong missionary presence in the region from the mid-1800s onwards had led many Merina to convert to Christianity. While the Merina upper class converted to Protestantism, the former slaves of the Merina nobles converted to a larger degree to Catholicism. During the colonial period and the early independence period after 1960, the adoption of Christian practices also became synonymous with upward social mobility (Rakotomalala, in Stoebenau 2010, 45). These practices included Christian marriage and more constrained views on sexuality than those that had traditionally been the norm in Madagascar (Cole 2010, 74). Moreover, in a pro-natalist effort to increase falling birth rates in France after the First World War, the implementation of a so-called anti-contraception law in Madagascar in 1920, further allowed for the proliferation of sexual puritanical discourses in the highlands. As well as prohibiting the importation, manufacturing, distribution and promotion of contraception, the law also criminalised abortion. Until an amendment to the 1920 law passed in the Malagasy Senate in December 2017, there was therefore no legal access to family planning services in Madagascar for anyone under the age of eighteen. Information on and access to birth control methods have thus until very recently only been available from health centres and by prescription in pharmacies (Blumenthal 2006; ANAVP and SRI 2014). Consequently, the contraceptive prevalence rate in the island has been very limited,[5] and clandestine abortions have sometimes been the only way to prevent unwanted pregnancies.

Views on fertility control may wax and wane according to national policies and international interventions, however. During President Didier Ratsiraka's first presidency from 1975 to 1993, contraception was next to impossible to acquire. As a Catholic, Ratsiraka followed the Pope's restrictive views on the use of modern contraception. Nevertheless, although Ratsiraka once again became President from 1997 to 2002, work by the Malagasy Ministry of Health and Family Planning still managed to increase the contraceptive prevalence rate from ten to 28 per cent between 1995 and 2008 with the introduction of etonogestral contraceptive implants (ANAVP and SRI 2014). During President Marc Ravolamanana's presidency from 2002 to 2009, HIV prevention was put high on Madagascar's public health agenda with the aid of international donors. Nevertheless, knowledge about sexually transmitted infections (STIs) and how to protect against them by using condoms, is still lacking especially among young people (Grant and Shoham 2018, 62; MDM 2018, 52). Following the 2009 coup d'état when almost all non-emergency international aid organisations withdrew from the island, health expenditure dropped drastically by 77 per cent between 2008 and 2011. As a result, maternal mortality rates increased. According to Morris et al. (2014) only 44 per cent of births are attended by a skilled health provider.

Resonating with an enduring dominant discourse of premarital abstinence in the central highlands (Stoebenau 2010, 14), mass media campaigns urge for delayed sexual debut to prevent the transmission of STIs (Stoebenau et al. 2009), while religious institutions encourage premarital abstinence on moral grounds (Cole 2010). Although neither of these approaches are necessarily practised, they both reflect the cultural values placed on female chastity among the Merina (Stoebenau et al. 2009, 5). To have many children is still considered desirable, but this should take place within wedlock. Despite this, the teenage pregnancy rate is among the highest in Africa with an adolescent birth rate of 148 per 1,000 as of 2010 (Morris et al. 2014). Moreover, the Malagasy non-governmental organisations ANAVP and SRI claim that more than 50 per cent of young women (15-24 years) from urban areas have had an abortion (2014).

While several private practitioners, especially in Antananarivo, are known to perform abortions (Gastineau and Rajaonarisoa 2010), obstacles concerning cost and transport leave many Malagasy women to pursue abortions elsewhere and by other, often less safe, methods. Unsafe abortions may be understood as a pregnancy that is terminated either by persons lacking the necessary skills, in an environment that does not adhere to minimal medical standards, or both (Grimes et al. 2006, 1908). Causing more than 68,000 deaths annually worldwide, unsafe abortion is held to be one of the most neglected sexual and reproductive health problems in the world today (Grimes et al. 2006). However, contrary to common normative belief, strict abortion laws do not prevent high abortion rates. Instead, due to higher contraceptive usage, the lowest numbers of induced abortions are found in countries with liberal abortion laws (Sedgh et al. 2012). Access to safe abortion is thus disproportionately allocated across the world, and unsafe abortion affects women in developing countries more than women in more developed regions (World Health Organisation (WHO) 2016).

While public post-abortion care is accessible across Madagascar to assist women who present with incomplete abortions and complications, the units that provide it are few and far apart (Blumenthal 2006). When Gastineau and Rajaonarisao (2010, 224)

claim that abortions are more prevalent in urban than in rural areas, particularly in Antananarivo, there is therefore reason to believe that this merely implies wider access to safer abortions. This includes the students in this study who, in contrast to most Malagasy women, can afford to pay the average cost of 50,000 Malagasy Ariary (USD 16.5) to have an abortion preformed at a private clinic. Although abortion remains illegal, it is still widely accessible both within formal and informal sectors in Antananarivo. However, women who visit such clinics form a relatively homogenous group, comprising largely non-married students below the age of 25 from higher middle-class backgrounds (Gastineau and Rajaonisara 2010, 224). The research participants in this study therefore comprise a particular group in relation to the rest of the Malagasy population who, for the most part, live in rural areas characterised by unreachability due to severe lack of infrastructure. As a result, rural women often face serious challenges gaining access to health care services, including family planning and post-abortion care (Blumenthal 2006). The problem of unsafe abortion is therefore tightly linked to wider issues of restrictive laws, poverty, poor availability of adequate and appropriate health care services, and lack of access to effective contraception.

In Madagascar, all of these barriers to safe abortion have a detrimental impact on girls' and women's health although, as will be discussed, less so among the students in this study. Not all students originate from Antananarivo however, and some come from other parts of Madagascar to the capital city to study. Many of the students therefore live for the first time without their parents. This leaves them with more freedom to pursue sexual relationships on the one hand, but also leaves them more vulnerable to sexual exploitation and peer pressure on the other (Zenebe and Haukanes 2019, 19).

Methods

Ethnographic fieldwork and anthropological data analysis were carried out by the author and a male research assistant. While the author speaks French, the research assistant speaks both French and Malagasy (Mahajanga dialect) and acted to a large degree as an interpreter in the field. The researchers' different genders proved particularly helpful in recruiting and engaging both female and male research participants. Possibly because the research assistant was European and not Malagasy, his gender did not appear to hinder discussion with the women who were rather unexpectedly open to discuss details regarding for example menstruation, sexuality and fertility control with both researchers.

Similar to Gastineau's and Rajaonarisoa's (2010) study, fieldwork took place in private family planning and health care facilities in different areas of Antananarivo. While Gastineau and Rajaonarisoa (2010) used quantitative methods such as questionnaires, this study relied on qualitative methods. We carried out 12 group discussions on fertility control with students at the University of Antananarivo that took place at the university's health centre. Five of the student groups were female only, five were male only, and two were of mixed genders. In total, we talked to 19 female and 20 male students.

While these students are the primary focus of this article, we also conducted semi-structured interviews with women who had received an abortion, and health care workers mainly recruited from three different private health clinics in Antananarivo that offer medical abortions and perform surgical ones clandestinely. Conducting semi-structured interviews allowed flexibility in order to encourage research participants to share their primary concerns regarding fertility control, while simultaneously allowing for the inclusion of specific research questions in each interview. Research participants were approached directly at the clinics. For those who agreed to participate after having been informed about the study, interviews usually took place in clinic staff offices, patient recovery rooms or stockrooms to allow for privacy. Interviews lasted from 15 min to an hour, both researchers took notes on site, and a more detailed field diary was written up afterwards. No interviews were recorded due to the sensitivity of the research subject in question.

Access to clinics was granted through their management. However, since abortion is illegal repetitions in Madagascar, studying it requires a particular research ethical sensibility and responsibility vis-a-vis participants. The clinics offer abortions clandestinely and some of the staff have previously faced criminal prosecution. Nevertheless, they still choose to continue to provide abortions.

In total, we conducted interviews with 27 women who had received an abortion, including three couples, and 12 health workers who were doctors, nurses, midwives or health administrators. The inclusion of health workers allowed us to use the snowball method to identify other abortion providers outside of the private clinics. This enabled us thus to map out alternative venues and options for clandestine abortions which, in turn, contributed to a more comprehensive understanding of the issue at hand. One such location was the black medicine market in Antananarivo where counterfeit drugs or Misoprostol used for medical abortions were widely available.

Data analysis was carried out in accordance with anthropological approaches, entailing careful repeated reading, interpretation and the discussion of field notes in order to identify emerging themes.

Findings

Perspectives on contraception

Until recently, the anti-contraception law in force in Madagascar has contributed to explaining the low contraception uptake among those under eighteen years of age, and among poor women living in remote rural areas. As mentioned earlier, students at the University of Antananarivo belong to neither of these two groups. Instead they come predominantly from middle and upper class families which, in most cases, value and can afford to pay for their education and board (Skjortnes and Zachariassen 2010). In order to focus on and complete their studies, some students therefore refrain from pursuing romantic relationships or remain sexually abstinent if they do so. Feno, a 27 year-old female student, considered for example sex before marriage to be a sin, and that using contraception before marriage would only lead young adults to 'misbehave' (field notes, 7 August 2017). Peta, a 20 year-old male student shared Feno's thoughts:

> To me, family planning is not good because you should not have sex before you are married. Once you are married, you should not use contraception either because then you should have children (field notes, 9 August 2017).

The majority of the students did not practise abstinence. As 23-year old Thomas pointed out; 'if you have a boyfriend or a girlfriend, you have sex. It is what happens' (field notes, 7 August 2017). Nonetheless, according to a staff member at the university's health centre which offers family planning services on campus, only ten to fifteen per cent of the University's 32,000 students actually use any kind of modern contraception (interview with Martha, midwife, 28 July 2017).

So why does the contraceptive prevalence rate among students in Antananarivo remain so low? As described in other studies on reproductive and sexual health among young adults in Antananarivo (see for example Gastineau and Rajaonarisoa 2010; MDM 2018), there appears to be a strong reluctance to use modern contraceptive methods. This is primarily due to worries concerning potential side effects. 25-year-old Fanaina explained:

> If I use birth control that has side effects, how long will it take before I have my normal body back? It is scarier to use contraception than to give birth, because giving birth is something all women do. I am therefore more afraid of the long-term effects of contraception on my body (field notes, 7 August 2017).

Here, Fanaina places her body, and the potential damage birth control can do to it, at the centre of her rejection of contraception. From a phenomenological perspective, the individual body and its corporeal experience provides the base on which how we relate to and orient ourselves in the world (Merleau-Ponty 2002 [1945]). Fanaina's conception of a body-self is closely linked to other Malagasy women's bodies and experiences with them, in this case of giving birth. Although a certain sense of self as distinct from others is universal, the dichotomy between individuals and society, which is fundamental to Western epistemology, is also rather unique to it (Scheper-Hughes and Lock 1987, 13-14). As in Fanaina's case, the phenomenological individual body is simultaneously a social body. Experience is intersubjective and embodied (Moore 1994, 3). Great social value is placed upon becoming a mother in Madagascar as this ensures the continuation of kindred (Skjortnes and Zachariassen 2010, 200). Fanaina's objection to the use of modern contraception can thus be understood both as an expression of personal beliefs and as the embodiment of Christian social norms and cultural life.

To pursue higher education entails postponing marriage and pregnancy for many students (Skjortnes and Zachariassen 2010). In some cases, premarital pregnancy is therefore considered a positive test of a woman's fertility (Gastineau and Rajaonarisoa 2010). Although the pregnancy may be unwanted and lead to an induced abortion, it is still a confirmation of the woman's reproductive capability. The majority of students who opposed contraception expressed considerable concern over whether it could cause future problems in conceiving a child, or even lead to infertility. As Thomas put it:

> If you use contraception, it can take at least three years before you start to have children. This makes people wary towards contraception since they no longer believe that they can have children at all (field notes, 7 August 2017).

In addition to infertility, increased body weight, cancer, infections and even death resulting from etonogestral birth control implants 'travelling' in the body, were

regularly referred to as other undesired side effects of contraception. As elsewhere in Sub-Saharan Africa, Sharp (2002, 28) also claims that family planning is sometimes viewed by Malagasy students as part of a neo-colonial agenda for population control by foreign aid agencies. This argument was not brought up by any of the research participants in this study. Instead many of the students acknowledged their need for birth control methods despite their unwillingness to actually use them. Rajery, a 23-year-old male student, said the following:

> It is not good for us kids to use contraception. It can be bad for girls. Then there is another side to the story: By using it, you will not make your girlfriend pregnant. I mean, I need it. I need condoms. Nonetheless, I do not use them because I do not like them. So instead, we count days. We pay close attention to the dates, and only have sex on those dates when it is okay, and not on the dates when it is not (field notes, 9 August 2017).

Rajery points to several issues regarding the reluctance to use modern contraception on the one hand, and the widespread reliance on the calendar method to control fertility among students on the other hand. Condoms were for example often reported to decrease sexual sensation, pleasure and intimacy by both men and women (Gastineau and Rajaonarisoa 2010). While men sometimes compared having sex with a condom to 'eating candy with the wrapper still on', some women complained that condoms removed the emotional intimacy associated with having sex. Hardly any of the students we interviewed mentioned anything about the risk of acquiring an STI when not using condoms. Instead, Hajo, a 26-year-old male student, explained how he had had to convince his current girlfriend to use condoms to prevent an unwanted pregnancy. In order to find out if a new girlfriend is what he called 'clean', meaning not pregnant or promiscuous, Hajo said that he insists on using condoms until she gets her period. In this case, his girlfriend had initially been against it since she claimed it would be easier for him to cheat on her if he did (field notes, 7 August 2017). Men and women alike argued that contraception could lead to infidelity since there was less risk of an unintended pregnancy. 19-year-old Dévisse who had had an abortion at one of the private clinics in Antananarivo one year previously, complained that for this reason many men claimed that 'you are not really boyfriend and girlfriend if you use condoms' (interview, 3 August 2017).

Views on menstruation

As a precaution against unwanted pregnancy, many students refrained from having sex altogether, or used condoms on so-called unsafe days of the menstrual cycle. 34-year-old Yolande who was married with 3 children and had come to one of the private clinics in Antananarivo for her second abortion, explained that to avoid the side effects she only took birth control pills between day nine and 20 of her cycle when she reckoned she was most likely to be ovulating (interview, 21 July 2017). In order for birth control pills to protect against pregnancy, they should be taken every day at about the same time. Nevertheless, Yolande was managing her reproductive health to the best of her knowledge. While many women are influenced by public health messages, they are also constrained by costs or access to healthcare facilities. As illustrated by the case of Yolande, they therefore care for their sexual and reproductive health in

diverted and adapted ways that often entail the use of both traditional and modern contraceptive methods (Hardon et al. 2019, 365).

Contraception that could cause a woman to cease to menstruate was often considered the most problematic form of birth control method among students in Antananarivo. Since so many relied on periodic abstinence for fertility control, keeping track of the menstrual cycle appeared to be just as much of a worry for the girls' partners as for the girls themselves. 27-year-old George who had been dating his girlfriend for six years, told us for example that the two of them had downloaded an app on their cell phones for this very purpose (field notes, 7 August 2017). In addition to their male partners' monitoring their girlfriends' menstrual cycles, some female students who still lived at home also mentioned how their mothers took precautions to check whether they were sexually active. According to the girls, their mothers would regularly ask them if they needed money to buy sanitary pads and, if not, when they would need it. In some cases, they also checked their towels for menstrual stains after they had had a shower. To use a form of contraception that would cause them to lose their periods could thus be taken as proof that they were sexually active despite being unmarried. Even birth control pills were considered problematic since they could cause increased body weight, which they believed that their parents might become suspicious of. Lalaina, who was a midwife who provided family planning services and medical abortions in secrecy, told us how she monitored her 22-year-old daughter's period. Since her daughter was studying away from home, Lalaina would call her regularly to ask her if her tummy was hurting. She also informed us that she had a close friend who lived nearby to her daughter who kept an eye on what she was up to and regularly reported back to Lalaina. Whenever her daughter came home, Lalaina also logged into her Facebook account and checked her messages to see if any of them could potentially be from a boyfriend. She expected her daughter to remain abstinent until she had completed her studies and got married. Only then would she consider providing her with contraception although her daughter had already (jokingly) asked her for it (field notes, 11 August 2019).

Female students' control of own fertility appeared thus to be strongly influenced by and in some cases monitored by their mothers. 23-year-old Seheno, who had had an abortion in one of the private clinics in Antananarivo one year previously, had for example been warned against using contraception by her mother:

> I did not use any kind of birth control before the abortion, and I do not use any now either. My mum told me: "Do not use it, just do not"! She said that it can make the baby malformed or handicapped. Besides, you are not supposed to not get your period. Menstrual blood needs to leave the body. Like other things inside your body, menses are dirty. If you do not have your period, the blood will accumulate and can lead to a *blocage* [blocking] (interview, 1 August 2017)

As argued by Douglas ([1966] 2002) in her seminal work *Purity and Danger*, the body and particularly fluids such as menstrual blood, breast milk, urine and semen are potent natural symbols and metaphors of society. To Douglas, the physical body is a social body that reflects the society in which it is located (Scheper-Hughes and Lock 1987). Notions of what is considered clean or dirty, pure or impure are thus not about hygiene, but rather concerns cultural conceptualisations of the body (Douglas [1966] 2002). Seheno's perception of the menses as 'dirty' may for example be compared to

Hajo's view that it is only when a new girlfriend gets her period that she is (morally) 'clean' in his eyes. Moreover, in crossing the boundaries between bodies' insides and outsides, bodily fluids are often conceived as 'matter out of place' (Douglas [1966] 2002). This suggests that something that is perceived as belonging in one place, becomes impure or taboo when it is no longer in its place of origin. In many cases, menstrual blood therefore requires specific purifying measures once it leaves the body. In Madagascar menstrual blood is considered a problem if it remains in the body since it can then lead to a *blocage*. Andry, a 23-year-old male first year medical student explained a *blocage* and its consequences as follows:

> It is a problem to use contraception before you have conceived a child. When you use contraception, it stops the organs that are used during conception. Similar to how a leg that is not being used can cause atrophy, contraception can therefore make it difficult to conceive later on. By not using your reproductive organs, you create a *blocage* in your reproductive system. The organs are supposed to be active at all times without any kind of interruption (field notes, 31 July 2017).

Here, Andry described *blocage* as a form of atrophy of the reproductive system caused by the use of contraception. Thomas in contrast related *blocage* to 'the Malagasy cultural opposition to anything that blocks or creates a blocking' (field notes, 7 August 2017). In this context, the Malagasy notion of *hasina*, described by Bloch (1977) as the kernel of Malagasy thought, may shed light on Thomas's assertion. *Hasina* is a sacred and life-giving power of creation that flows through and connects the living to their ancestors (Dahl 1999, 26). Although the majority of the Merina are Protestant or Catholic, very many also practise traditional religion in syncretism with Christianity. That is, belief in ancestors is central to the well-being and fortune of the living (Bloch 1971). Similar to *mana* in Polynesia, *hasina* can be understood as a 'generative potency' and vitality that comes from the gods (Shore, in Tomlinson and Tengan 2016, 7), or the ancestors in the case of the Merina in Madagascar. According to Cole (2010, 73), the ability to bear and care for children is one of the most important ways in which Merina women can generate *hasina* and become valued and respected members of their families and society. Not only do children ensure the social reproduction of kindred, but children also provide important evidence of ancestral blessing (Cole 2010, 56). A *blocage* can therefore signify a problem in women's contractual relationship with her ancestors (Dahl 1999, 26), leaving her disenfranchised from both her living and her 'dead' relatives.

Due to patrilocality whereby the bride moves to her husband's family upon marriage, her children will in most cases be placed in the family tomb of their father (Bloch 1978, 24). Moreover, since the general norm for Malagasy women is to care for kindred (Skjortnes, in Skjortnes and Zachariassen 2010, 197), decisions regarding a woman's use of birth control often include the whole family (interview with Dr. Georgette, 19 July 2017). This was at least the case for 31-year-old Tanteraka. Tanteraka, who was married with two children, had come to see midwife Lailana for a medical abortion. Since both her husband and her mother-in-law were against contraception, she had never used any (interview, 11 August 2017). While reflecting on this, Tanteraka said she did not really understand why, since her family was Lutheran and not Catholic.

As discussed previously, conservative Christianity is highly influential among the Merina in the highlands and plays a central part in people's perceptions of sex and fertility control (ANAVP and SRI 2014). This is enhanced by a close contact between the church and communities through diaconal work that often delivers social services that the government itself is unable to provide. In addition, when under both real and imaginary threats, nation states tend to respond by increasing the surveillance and control of their citizens' bodies (Douglas, in Scheper-Hughes and Lock 1987, 24-25). Due to its links to nation building, the regulation of sexuality and reproduction is therefore of particular importance (Foucault 1980). To secure a strong nation, high fertility is in the interest of the state.

'Cleaning the womb': Blocage and abortion

Although Feno, Peta and Lailana's daughter might not engage in premarital sex, as already mentioned the majority of the students who participated in this study did do so. The median age for Malagasy women's first sexual encounter (age 17 for women aged 25 to 49) is for example lower than the median age for their first marriage (19 years old for women aged 25 to 49) (ENSOMD 2013, 40). Because of this, public health institutions and non-governmental organisations often target students for family planning services. The midwife Martha who was in charge of such services at the university's health centre, claimed to encounter about fifteen girls with unwanted pregnancies every month (field notes, 28 July 2017). Some of these pregnancies were terminated by either safe or unsafe means. Since abortion is illegal and costly, many Malagasy women visit traditional midwives, or use herbs or herbal concoctions with abortifacient effects (*tambavy*) to terminate an unwanted pregnancy (Sharp 2002). Three female first year medical students in their early twenties listed the following methods that to their knowledge could lead to an abortion: massage of the stomach, the morning after pill, candy and vinegar, Coke and Misoprostol, a doctor, and/or a private health clinic (field notes, 28 July 2017). When asked whether they were more afraid of the possible side effects of contraception or of having an abortion, most of the female students answered that contraception was more worrisome.

Of the 27 women we interviewed who had received abortions, 15 had undergone medical abortions through midwifes such as Lailana, and 12 had had surgical abortions in private clinics. In the clinics, women were, at least according to the health workers, always given the option between having a medical or a surgical abortion. Medical abortions are induced by providing women with the drug Misoprostol that is also used as treatment for incomplete abortions. However, to my knowledge, the clinics only offered abortions during the first trimester and only by manual vacuum aspiration (MVA) in order to reduce the risk of complications, and consequently, avoid any attention from the Malagasy authorities. Although Misoprostol, when used correctly, has been proven to significantly reduce the health risks associated with unsafe abortion methods for at least up to 12 weeks, it can also be self-administered and is therefore increasingly sought after in countries where abortion is illegal. Most likely for this very reason, Misoprostol has still not been approved for use in private practices in Madagascar, and only became officially available for post-abortion care in the public

health sector in 2017 according to the health administrator Osana (field notes, 14 August 2017). A recent study shows, however, that Misoprostol is still easily accessible in Madagascar, but that the instructions on how to use the drug are variable, do not match WHO guidelines and often result in ineffective or incomplete abortion, with sometimes severe side effects (Pourette et al. 2018). Dr. Eric, who was in charge of a private clinic in Antananarivo, said the following about the black medicine market:

> They sell something that does not contain 100 per cent Misoprostol, the clients do not know how to use the drugs, and they end up here after an unsuccessful attempt at abortion. The women should start to feel some side effects of Misoprostol such as diarrhoea or pelvic pain, but they feel nothing. After one or two weeks, they come here, and are offered two choices if they still want to have an abortion: Either real Misoprostol or an MVA. It is not really due to complications so much as that the drugs do just not work. If the woman chooses a medical abortion, we do not tell her the name of the drugs so that she does not buy it herself at the black market instead of here (field notes, 20 July 2017).

Without exception, all of the women who received abortions at the three clinics in Antananarivo had a manual vacuum aspiration regardless of gestational age. MVA Manual vacuum aspiration is not only considered safer and more efficient than a medical abortion, but also abortion recipients also often said that they chose the procedure because it 'cleans everything out'. Since menstrual blood that remains in the body in some cases was perceived to create a *blocage* of a woman's reproductive capacities, having a period was also frequently referred to as a 'cleaning [out] of the womb' (Rajo, 21-year-old female, field notes, 2 August 2017). This was similar to how abortion patients described manual vacuum aspirations. Moreover, while counterfeit drugs used for medical abortion could potentially create a *blocage* in the form of an incomplete abortion, a successful one was sometimes simply referred to as 'getting your period back' (interview with Lanjo, 38-years-old, 9 August 2017).

Concluding remarks

This article has aimed to contribute to knowledge on how students in Antananarivo handle their sexuality and fertility within the local legal, socio-economic and social-cultural frame. Even if they do not practise premarital abstinence, they still adhere very much to a prevailing Christian discourse of premarital abstinence as expressed among the Merina in Madagascar's central highlands. Moreover, if family planning is indeed about planning a family, young women who are not planning for a family yet may not see contraception as a fertility control option that applies to them. This may be a particularly pertinent issue for unmarried female students who strive to fulfil their parents' educational expectations on the one hand, and their own hopes for increased independence on the other (Skjortnes and Zachariassen 2010, 198, see also Zenebe and Haukanes 2019).

Although contraception is available in Madagascar, contraceptive prevalence remains low among students in Antananarivo primarily because of cultural barriers. Rather than losing your period by using contraception, and thereby risk causing a *blocage* and future infertility, many female students in Antananarivo preferred, at least in theory, to 'clean their wombs' and 'get their period' back through abortion when

dealing with unwanted pregnancy. Moreover, by employing periodic abstinence or the calendar method for fertility control, they reckoned that there was less risk that their parents would discover that they were sexually active. In addition, boys would assume that girls who menstruated were not on birth control and were therefore less prone to promiscuity or infidelity. In this regard, cultural conceptualisations of menstruation functioned as moral control of sexuality at both an individual and a collective level by way of *blocage* and the central Malagasy concept of *hasina*. In addition, since so few students seemed to use condoms, this also put them at greater risk of contracting STIs (Grant and Shoham 2018).

Despite students' concerns, modern contraception does not lead to infertility, but untreated cases of chlamydia and gonorrhoea can. The need for family planning among students is thus still largely unmet in Madagascar. Amending the 2017 anti-contraception law may have been a first step towards meeting these needs, but Madagascar still has a long way to go when it comes to sexual and reproductive health rights. Understanding girls' and women's own concerns and desires, and the cultural impediments that hinder them from practising safe sex or avoiding unwanted pregnancy, is not only essential in this regard, but also potentially lifesaving when it comes to the issue of unsafe abortion in the island.

Disclosure statement

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Notes

1. Criminal law principles of necessity opens up the possibility of abortion to save the life of a pregnant woman, but even then they require the attending physician to consult with two additional medical doctors, one of whom must be on a list of experts provided by the Court.
2. As of 2018, Madagascar's maternal mortality rate was estimated to be 353 per 100,000 live births (Médecins du Monde 2018, 8).
3. The concept of unmet need for contraception refers to why women who do not want to become pregnant for at least another two years, and have access to contraceptive options, still do not use them (Sinai et al. 2019).
4. There are 18 official ethnic groups in Madagascar. The Merina is the largest and makes up about 25 per cent of the total population.
5. Approximately 28.8 per cent among 20-24 year-olds, while the equivalent rate is only 13.7 per cent among 15-19 year-olds (Médecins du Monde 2018, 14).

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