

# Fake-talk, Side Effects

## And the Trouble with Hormonal Contraceptives among Women in Dar es Salaam

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Received: 30 June 2022; Accepted: 18 April 2023; Published: 27 September 2023

### Abstract

This article analyses women's accounts about hormonal contraceptives in Tanzania, and the social, cultural, political, and economic contexts that cause them to use such contraceptives, even as they called them '*feki*' (Swahili for fake). Drawing on four months of ethnographic fieldwork and interviews with four working-class women from various districts in Dar es Salaam, my research explores their anxieties about using these medications, the side effects of which they believe pose a threat to their health. The possible biomedical side effects the women spoke of include prolonged menstrual cycles, stomach cramps, fibroids, cancer, and infertility. They reasoned that medicine should not bring suffering to the body, and that therefore, if a woman experiences side effects it is a matter of concern. Given that all medications have side effects, I was interested in what exactly these women meant when they identified hormonal contraceptives as '*feki*'. Furthermore, if they believed that these contraceptives were fake, why did they continue to use them? Over time, I came to understand that calling hormonal contraceptives '*feki*' did not mean the women thought the pharmaceuticals were inauthentic or ineffective in preventing pregnancy. Rather, it reflected their view of such drugs as being morally problematic, but sometimes necessary.

### Keywords

Gender, Reproductive health, Fake pharmaceuticals, Contraceptives, Tanzania.

## Introduction

This Research Article analyses women's accounts of using hormonal contraceptives in Tanzania, and the socio-political and economic contexts that cause them to continue to use of them, even as they call them '*feki*' drugs (Swahili for fake). Drawing on four months of ethnographic fieldwork and interviews with four working-class women from various districts in Dar es Salaam, my research explores these women's anxieties about using these medications, and the side effects of which they believed posed a threat to their health.

The women's knowledge of hormonal contraceptives was greatly influenced by their own experiences of these medications and by stories they had heard from other women in their communities. Reasoning that medicine should not bring suffering to the body, they were concerned about its side effects. The possible biomedical side effects of these hormonal medications they spoke of included prolonged menstrual cycles, stomach cramps, fibroids, cancer, and infertility. Given that all medications have side effects, I was interested in what exactly these women meant with side effects when they identified hormonal contraceptives as '*feki*', as fake. I further wondered why, if they believed the contraceptive drugs were fake, they continued to use them? Over time, I came to understand that calling hormonal contraceptives '*feki*' did not mean the women thought the pharmaceuticals were inauthentic or ineffective in preventing pregnancy. Instead, it reflected their view of such drugs as being morally problematic, but sometimes necessary drugs to take.

As I began carrying out my interviews, I noticed that these women used the term '*feki*', borrowed from the English word 'fake', to cast these contraceptives as somehow suspect. For example, one woman dismissively remarked, 'Honestly, all those drugs have problems, they're all *feki*'. I wondered why they did not use the Swahili word for fake, '*bandia*' instead, or its opposite, '*halali*' [legitimate or honest], as in '*hio dawa sio halali*' [that drug isn't legitimate].<sup>1</sup> Over time, I discerned that '*feki*' was used primarily in everyday conversations in the community, while the word '*bandia*' was used in more authoritative domains and the word '*halali*' was used to describe the actions of moral agents. By paying attention to the use of '*feki*', I began to see that the term was used to cast whole domains of activity—such as informal economic activities—as slightly suspect.

Close study of these women's accounts also suggests that it may be useful to expand the concept of side effects when thinking about social and moral dilemmas relating to contraception. The women I interviewed believed that taking contraceptives would bring about other consequences beyond biological changes

1 '*Halali*' is a Swahili word derived from the Arab word 'halal', meaning legitimate, lawful, or legal.

in their bodies, what I call ‘social side effects’. That is, their attitudes towards contraceptives were influenced by how people in their communities would view them if they knew they took hormonal contraceptives. Having many children shaped how the women in my study viewed themselves and their roles in their communities, as it gave them a certain level of social status and power. They believed that using contraceptives meant that a woman was not fulfilling her primary duty of having children. This view of reproduction could be linked to national narratives that emphasise the importance of fertility, making motherhood part of being a good moral citizen in Tanzania. These women’s accounts made it clear that side effects could be moral as well as biological.

One of the women I interviewed, Theresa<sup>2</sup> said that having children is an important aspect of a woman’s life. However, she also talked about the social and economic constraints that could bring challenges when having and raising children, saying:

To have a child, you have to have money, in order to feed your family. Sometimes, other pregnancies can give you problems. You are always sick. You cannot work. And at the same time, you have a man that lies to you. Honestly, [with] the life I live, I cannot have more children.

Theresa explained that she had stopped using contraceptive injections because she got ‘stomach aches, like period cramps’. In spite of that, given the lack of support she received from the man who had abandoned their child, she decided once again to use hormonal contraceptives. Other women also spoke about the challenges of navigating relationships and complained that the men in their lives were often unwilling to listen to their reasons for not wanting more children. When their relationships failed, many were left with the financial burden of raising their families. Through the lens of social side effects, we can see how using contraceptives may help women withstand their partners’ and society’s expectations about their bodies. For the women I spoke to, these social, cultural, and economic constraints meant that they constantly had to navigate the social norms placed on them. Using contraceptives while also calling them ‘*feki*’ allowed them to navigate a particular dilemma: preventing pregnancy while maintaining their image as respectable women. By calling the drugs ‘*feki*’, they placed the burden of moral and social waywardness not on their own actions but on the suspect drugs.

Using Hornberger and Hodges’s concept of ‘fake-talk’ (see Hornberger and Hodges, this issue), I argue that calling these drugs ‘*feki*’ allowed the women to transcend this dilemma and live the contradiction—to both be *halali*, honest, proper, and take contraceptives. By dismissing the drugs as ‘*feki*’, these women

2 All the names of the women mentioned are pseudonyms.

sought to deflect criticism for not having more children or for not adhering to the ideal image of the Tanzanian woman, and to cast aspersions on the drugs themselves. Their fake-talk should thus be understood in relation to the challenge of being an authentic, ideal Tanzanian woman, one who embraces the national ideal of motherhood, while also limiting her fertility. Fake-talk allowed women to navigate social and economic tensions, permitting them to express something not sayable, namely that they have to take contraceptives and yet cannot take them.

By taking seriously women's experiences of hormonal contraceptives and by looking at the social, political, and economic constraints on their lives, my research brings the study of fakeness and 'fake-talk' into conversation with matters of gender, sexuality, and reproductive health. In this particular case, the women's experiences led them to identify hormonal contraceptives as fake and to choose to take them anyway because of the power struggles and social and economic inequalities in their lives. To make this argument, I explain first the context in which the idea of '*feki*' contraceptives arises, and then move on to discuss how the use of '*feki*' refers more to concerns about the side effects than to a drug's success in preventing pregnancy. Finally, I discuss how claiming to use '*feki*' drugs allowed a woman to maintain her *halali* image.

## **The threat of fake pharmaceuticals**

Over the last few years, public health researchers, policymakers, and news outlets have warned of the proliferation of counterfeit pharmaceuticals and their threat to the health of people in the global South. For example, in January 2020 the BBC published an article entitled 'Fake Drugs: How Bad is Africa's Counterfeit Medicine Problem?', which characterised fake medicines in Africa as a public health crisis in need of immediate intervention (Mwai 2020). The article notes that 42% of all reports of counterfeit medicines made to the World Health Organization (WHO) between 2013 and 2017 came from Africa, and that India and China are the largest producers of the drugs circulating in developing countries (Ibid.). The article concludes that these drugs have caused unnecessary morbidity and mortality, as well as a loss of public confidence in medicines and health systems.

A similar article in *The Guardian*, 'Fake Drugs Kill More Than 250,000 Children a Year, Doctors Warn', described a recent surge in counterfeit and poor-quality medicines intended to treat malaria or pneumonia. It called for support from the WHO and the UN to ensure that at least 90% of the medicines in these countries were of high quality, and for reports on the quality of their drugs to be publicly available (Sample 2019).

Both these news stories frame the problem of counterfeit or ‘fake’ pharmaceuticals as twofold: first, these medicines pose a threat in terms of treating certain conditions; and second, their spread needs to be controlled.

Recently, some scholars have asked whether this increase in fake pharmaceuticals has actually been substantiated, concluding that the ‘fake drugs’ narrative has taken on a life of its own (Hornberger and Hodges, this issue; Hodges and Garnett 2020; Hornberger 2019). Sirrs (this issue) provides a valuable history of the evolving institutional terminology used by the WHO on this subject. While these studies provide important information, I am interested here in yet another aspect of the fake drugs problematic: what do ordinary people mean when they talk about fake drugs? My research shows that medical and pharmaceutical institutions, governments, and national organisations do not have the sole power to identify or make meaning when it comes to the fake. I argue that we must examine why people may identify certain drugs as fake and what this means to them, rather than presume any correspondence with regulatory definitions.

### **Destabilising the fake category**

For the women in my study, calling contraceptives ‘*feki*’ did not mean they were inauthentic and therefore ineffective at preventing pregnancy. In coming to understand this, I was inspired by a set of anthropological works that approach the fake as an ambiguous category rather than as something opposed to the notion of the authentic or authenticity. Anthropologists have shown that claims of fakeness can both mean and do different things. The book *Fake* (Copeman and da Col 2018) offers a collection of cross-cultural analyses interrogating the concept of the fake and its multiplicity. For instance, the fake can shape and reveal social relationships and social hierarchies (Jones 2018); whilst declaring something to be ‘fake’ can be a form of exposure (Copeman 2018, 63). Jones (2018) argues that anthropologists have historically focused on exposing fakes, masked rituals, or trickery. Taking a different tack, in this book authors show how copies, counterfeits, or phonies are used to gain access or advantage where one would not otherwise have had it. Fakes, others have argued, can also be treated as authentic sources of power and value (Newell 2013). Newell’s (2013) study of Ivorian dandies illustrates that those dandies who buy counterfeit brand-name clothing, knowing it is fake, do so because it can still elevate their status. Here, fakes transcend the characterisation of a threat and instead gain authenticity through performance. In other words, fakes exist where there are normative standards of conduct that can be manipulated (Jones 2018, 16).

Importantly, Copeman (2018) argues that debunking the fake does not simply result in reasserting the truth; exposing a fake also works to expose various social relations. For instance, the dandies wearing counterfeit brand-name clothing as in

the case of Newell's work, people are aware of the fake yet are willing to suspend their disbelief in order to increase their chance of belonging (Copeman 2018, 70). What the works by Jones (2018) and Copeman (2018) both show is that by proclaiming the fake, things happen, and social relations and lines of inclusion and exclusion may be shifted as a result.

Recently, in her work on homosexuality in Malawi, Cal (Crystal) Biruk (2020) has been particularly explicit in their approach to the fake as an ambiguous category, one that upsets normative spaces. In efforts to qualify for non-governmental organisations' (NGO) aid, Biruk (2020) shows, attempts to determine who is a 'fake' gay and who is a 'real' gay, exposes the fiction of stable identities. Queer spaces, they argue, destabilise any dichotomy between the fake and the authentic. Like Jones (2018), they argue that the fake only exists when there are socially constructed standards of behaving that one can manipulate.

Taken together, these anthropological works suggest that debates about the fake are expressive of and interactive with a particular moral setting. This is the theoretical sense I take forward in my own work in explaining what the *feki* does to these women in the context of Tanzania. I am interested in how *feki* contraceptives are used to navigate the highly normative and socially regulated landscape of gender and reproductive health. As I will show, both the women's experiences of the medication and their fear of its social side effects shaped how they talked about pharmaceuticals as *feki*. As I will demonstrate, the *feki* in my account upsets what is supposed to be a seemingly obvious dichotomy for the women in my study: to be a morally upright woman or to take contraceptives.

## Experiencing the '*feki*'

Having grown up in Tanzania, to me 'fake' drugs (*dawa feki*) are a familiar topic. My family has long expressed the fear that *feki* drugs circulate in the country, and growing up we were always told to be careful about the drugs we use. At first, I thought such talk only occurred in my family. However, as I grew older and started engaging more with the people in my community, I noticed that they too were cautious about *feki* drugs. The brand name, the country from which the drug was imported, which pharmacy the drug was bought from, who was selling the drug—all these factors influenced how we learnt to deem a drug fake. Perhaps most important was people's experiences of a medicine. For example, my family did not use Panadol—a brand-name version of paracetamol used to treat fever or pain—from a specific pharmacy in an area called Sinza, not because the Ministry of Health had issued a warning about it but because our neighbour Doreen had bought it from that same pharmacy developed a skin rash. Both personal experience and stories about other people we knew thus influenced what medicines we bought or used.

Stories and rumours about certain drugs being *feki* also played a role in the kinds of medication I took, and the places I went to purchase them. These accounts acted as a sort of mediator for whether I would identify certain drugs as ‘*feki*’ or not. Similarly, I found that women’s accounts of hormonal contraceptives were informed by their lived experience, close and distant acquaintances’ experiences, and even rumours about these medications. They were also shaped by national policies that limited contraception and family planning.

### **Magufuli calls for women to ‘give up’ contraceptives**

In September 2018, President Magufuli toured the Lake Zone, the Meatu District in Simyu Region in northern Tanzania, and made some memorable remarks that were widely reported in the press (see e.g., Durosomo 2018; The Citizen 2018). As one news outlet put it, in doing so he ‘chided those who use family planning, terming them “lazy”’ (The Citizen 2018). He declared, ‘You have cattle. You are big farmers. You can feed your children. Why then resort to birth control? This is my opinion; I see no reason to control births in Tanzania’. He also placed the issue of population growth in an international context, stating: ‘I have travelled to Europe and elsewhere and have seen the harmful effects of birth control. Some countries are now facing declining population growth. They are short of manpower ... Women can now give up contraceptive methods’ (The Citizen 2018).<sup>3</sup>

Many people hearing these remarks in the news, or hearing about them later on, believed that the president meant to ban contraceptives. A few days later, *The Citizen* (2018) reported that the Ministry of Health was trying to clear up confusion about whether such a ban was imminent and declared that no such ban was expected. And indeed, while no outright ban was established, on 19 September 2018 a policy directive ordered all media outlets and non-government organisations (NGOs) to cease all family planning advertising (Mangago 2018).

The government began its crackdown by contacting agencies funded by the United States Agency for International Development (USAID) that were involved in birth-control projects and telling them to stop running any advertisements on family planning in the media. Many international organisations and human rights groups criticised the directive, with Amnesty International calling it an attack on people’s sexual and reproductive health (Adebayo and Odutayo 2018). With this new order, information about contraceptives effectively became more difficult to access. From then on, it became common to hear that contraceptives should only be prescribed for those who had ‘real health issues’, although there was no consensus on what those ‘issues’ were (The Citizen 2018).

3 Although women in Tanzania are an increasingly important part of the paid workforce—80% of all women are now in paid work (World Bank 2022)—most women’s lives are still dominated by their role in their family.

It is important to note that president Magufuli appeared to invoke the narrative around women that had existed during the liberation struggle in Tanzania: that women were the caregivers or nurturers of the nation, producing children in order to sustain and strengthen it. He was also drawing on wider historical practices of voicing ambivalence about the development discourse that encouraged contraceptive use to hasten a particular form of modernity. In Magufuli's eyes, women needed to bear children for the betterment of the nation and its economy. To him, contraception's potential to control reproduction was a problem for the nation's population and labour force.

These sentiments were widely echoed and further developed in the popular realm, especially on social media. In the months following Magufuli's order, the topic of '*feki*' contraceptives emerged in everyday conversations around the city, on social media, and in popular news outlets. For instance, Kiziuo, a user of a popular forum in Tanzania called *Jamii Forum*, began a conversation on 3 August 2018 titled [The dangers of using modern contraceptives as women forget the best methods to prevent pregnancy are using condoms or the calendar system only!'<sup>4</sup>] (Kiziuo 2018). In the post, Kiziuo argues that all other contraceptives are ineffective and in fact do more harm to a woman's body than the condom and the calendar method<sup>5</sup> do.

Some commenters agreed with Kiziuo, while other users insisted that all contraceptives were dangerous to women's reproductive health. For instance, Grahnman (posted on 3 September 2018) responded by writing: 'contraceptives are dangerous. It is better to reproduce than to use modern contraceptives'. This user then proceeded to list various dangers, which could be considered both social and biomedical side effects, stating that 'contraceptives can cause ovarian cancer' and that 'contraceptives ... make a woman barren therefore affecting a man's libido'. This post gained a lot of traction with many 'likes' and comments. Other people posting on *Jamii Forum* expressed similar opinions of and fears about contraceptives, with some calling these medications fake, such as user Amanikullaya (posted on 29 May 2019). For example, a user named T14 Armata posted: [Elsewhere, people claim that makeup and modern contraceptives are good. But I add that if *feki* was even priced well, in Bongo [nickname for Tanzania] we use very bad products, and they are allowed].<sup>6</sup> Thus, the topic of *feki* contraceptives during this time echoed various opinions about the quality of these

4 My own translation. From the original in Swahili: 'Madhara ya kutumia vidonge vya uzazi wa mpango huku wanawake wakisahau njia bora ya kupanga uzazi ni kutumia kondom na kalenda tu!'

5 Whereby a woman tracks her menstrual cycle to predict when she will ovulate and be most likely to conceive.

6 My own translation, from the original in Swahili: 'Kwingine watu wanadai vipodozi na njia za kisasa za uzazi wa mpango. Ila ni naongeza viwe feki au bei nafuu. Bongo tunatumia bidhaa za ovyo sana na zinaruhusiwa'.



drugs, and at the same time encouraged the control of women's use of contraception and family planning.

### **Popular knowledge: 'Other women' warn about side effects**

Both personal experience and popular knowledge of contraceptives' side effects played an important role in how the women in my study viewed various contraceptive methods, more so than information produced by medical institutions. Some medical information is not very accessible to the general public in Tanzania, in part due to its clinical and technical language. Also, people associated with the medical profession are seen as authoritative and powerful, and there is not always room to comfortably question that authority. In contrast, popular knowledge about medicines, disease, and health circulates easily, and perhaps especially in times of uncertainty and poor access to biomedicine. As a result, the general public construct their own meanings about medicines.

Rumours and gossip are one way in which unofficial messages are passed from one person to another (Bowen 2007, 70). Usually, people are more concerned with the information being conveyed, the individual it is about, or the actions taken by the individual in question than with whether the message is legitimate (Das 2007). Furthermore, rumours and gossip often arise at times when change is underway; and they can exercise great sway over those hearing them (Bowen 2007, 70). In the context of contraceptives, the messages and the people who pass them on can have considerable influence on women's use of contraceptives.

Most of the women I interviewed spoke of 'other women' in their community who had given them advice about hormonal contraceptives. They kept the identities of these other women vague, using words like 'they' or 'people' rather than revealing who they were. Nevertheless, the experiences of those 'other women—whoever they were—'influenced my participants' use of these medications. Jane's negative opinion of intra-uterine devices (IUDs), for example, was based on stories of other women's experiences of this method, as she had not used it herself. Similarly, Theresa's choices of contraceptive methods were influenced by unnamed people she had spoken with.

I found it interesting that in all the stories I heard, these 'other women' remained a mystery. Such vagueness is a classic way in which gossip and rumour work: the author or the signature of the author is erased or lost (Das 2007). Once, when I asked Theresa whether she knew of other women who had experienced similar negative side effects of hormonal contraceptives, she said, 'No! You know when it comes to these things, you don't ask'. Her reaction suggests that women may keep their experiences with hormonal contraceptives a secret. But because the stories that circulated were supposedly based on other women's experiences, they were

deemed legitimate; in this way, women gained access to information they would not otherwise have received.

I argue that anxiety about fake contraceptives in the country, due to both the global discourse on fake drugs and national policy changes regarding contraceptives, has shaped the public's everyday conversation about fakes. As a result, narratives about fakeness and the prevalence of fake drugs have been generated and circulated in social spaces. In this case, social media is significant because it further shaped the social relationships that people have with drugs.

In their book, *The Anthropology of Pharmaceuticals: A Biographical Approach*, Van der Geest, Whyte, and Hardon explore pharmaceuticals as social and cultural phenomena. They do this by exploring the 'life cycle' of medicines, from production to marketing to prescription to efficacy, in order to argue that people's values, beliefs, and ideas influence whether they trust in biomedicine (Van der Geest, Whyte, and Hardon 1996, 157). Similarly, Lock and Nguyen (2010) have argued that scholars should attend to the 'local as biomedical practice'. By the 'local' they mean the social, cultural, political, and economic contexts that influence people's use and experience of biomedicine. We can see the influence of the local not only in my family's avoidance of Panadol, but also on the national stage in president Magufuli's calls to women to halt their use of contraceptives. As Lock and Nguyen (2010) contend, biological definitions of healthy and/or 'normal' are shaped by cultural and social influences and understandings of gender. As seen in the context of Tanzania, women's normative bodies are greatly determined by their reproductive capabilities.

Magufuli's call for women to stop using contraceptives, and its underlying message that women's value lies in their ability to have children in order to build the national economy, is an important aspect of the wider socio-political and economic context that influenced people's understanding of pharmaceuticals. Those who opposed this value were seen as opposing a whole raft of social, cultural, and political ideologies and beliefs about women and their role in the country. As we shall see, when women called a drug '*feki*', it said less about the quality of a drug and more about how women navigated the use of contraceptives in this context.

## **Women's access to contraceptives in Tanzania**

In scholarship on Tanzania's healthcare system and access to reproductive health, there are two main strands: first, there is development research that is often 'donor-driven', meaning that it is shaped by donor needs and preferences. This research recognises that women in Tanzania have limited access to contraceptives and mainly focuses on diseases, reproduction, and the HIV/AIDS epidemic. More importantly, this line of research supports the use of contraceptives and increasing

women's independence and agency over their reproductive capacities (Sharp 2000, 300). A second strand shows that while reproductive health and family planning methods in Tanzania are available to the general public, relatively few women use them. As in many other sub-Saharan countries, the most popular contraceptive methods in Tanzania are condoms, pills, and injectable contraceptives, with a very small number of women using intra-uterine devices (IUDs) (Kahabuka et al. 2014).

Scholars have described how various social, cultural, and economic factors, such as low education level and poverty, result in the poor uptake of health services. Indeed, Tanzania's economic growth is unequally distributed, with 49.1% of the population living below the international poverty line in 2018; this equates to about 14 million Tanzanians living on US \$1.9 per day per capita (World Bank 2020). The majority of the population lives on less than US \$1.25 per day (Levira and Todd 2017). Bintabara and colleagues (2018, 2) found that women have particular problems accessing healthcare because of the following four factors: having to get permission from their spouses or family member, having to obtain money, the distance to the health facility, and not wanting to be alone (lack of spouse or family member escort). Given these constraints, women often access healthcare services through a *duka la dawa*, or drug store (Rutta et al. 2015).

*Duka la dawa* are the largest retailers of non-prescription medicines in the country and are overseen by the Tanzania Food and Drugs Authority (TFDA). These shops are heavily used for the purchase of medicines because there are few registered pharmacies outside the country's major urban centres. Thus, they provide essential services to rural and peri-urban residents. They have also proved essential for the provision of medicines at times when public facilities experience drug shortages. Some *duka la dawa* also administer medical services, such as malaria testing. However, they are considered somewhat suspect because most of them also illegally stock, sell, and dispense a range of prescription-only drugs (Rutta et al. 2015, 2). It is from these shops that many women get their contraceptives.

When Theresa began using contraceptives, she started getting hormonal injections at a *duka la dawa*. Her choice to use contraceptive injections was influenced mainly by their affordability, their discreet accessibility, and their common use by many women in her community. Theresa recalled that other women had also told her, when 'you go to a *duka la dawa* to get your injections, no one asks you questions like in the hospital. All you need to do is pay for the injection'. Tanzanian women are reluctant to disclose their sexual history, because doing so risks damaging their social identities. Going to a *duka la dawa* means that

they can avoid the questioning, scolding, and requirement to bring their sexual partners to appointments that women using healthcare facilities encounter.

At the same time, having internalised the link between maternity and the country's struggle and success, the women also believed it was important to contribute to the growth of the nation. They took great pride in being part of the community and identity of 'Tanzanian culture', and they dreaded being seen as not belonging. As many scholars have long argued, nations are predicated on inclusivity and exclusivity. This requires the creation of an 'other', that is, one who does not hold the characteristics or identity of the nation and therefore exists outside the boundaries of the political community. Being othered and excluded was not an option for these women, and thus they strongly wished to be viewed as good moral citizens. The women in my study constantly negotiated their agency and their social and bodily autonomy in a cultural and political climate that placed limitations on their choices. Their 'fake-talk', centred on the word '*feki*', expressed a tension between two beliefs about contraceptives: they are widely available and they are morally tainted. Getting contraceptives from a *duka la dawa* was a way to navigate this dilemma.

## **Methods: Talking about contraceptives**

Halima, Theresa, Jane, and Nusra, my four interlocutors, all lived in Dar es Salaam during my fieldwork, and all identified as black and heterosexual.<sup>7</sup> Theresa, Nusra, and Halima were married and had children; Halima was in a polygamous marriage as the second wife to her husband. Jane had no children but was in a committed relationship. These women all belonged to the working class, and although they were economically independent, they were not at complete liberty to get contraceptives from private hospitals or abroad. Instead, they participated in the informal economy where fake products are believed to circulate.

During the four months I spent with these four women, I conducted semi-structured interviews, recorded their life histories, and carried out participant observation in the context of their homes and where they worked. Some of them I contacted via referral while others I chose from my own contacts, on the basis that they could give me a particular perspective on the phenomena under study. Thus, some of these women were women I grew up and went to school with, and all are now part of my community. Furthermore, although the findings in this article are based on the formal interviews I conducted with these women, it is important to note that I have framed and situated my analysis within wider conversations I have had with

7 My interlocutors lived and worked in various residential and business districts in Dar es Salaam, including Sinza Palestina, Kariakoo, Mbezi Afrikaana, and Msasani Peninsula.

other women in my community, my friends, family and healthcare providers, and in relation to further information I have retrieved from social media for some time.

I first met Theresa in 2017, about two years before my research began, when she was working as an assistant at a tailoring shop where my mother had her clothes made. I became more familiar with Theresa when she came to my house to get measurements from my aunt, who was unable to leave the house because of a disability. Theresa would tell us the local gossip, noting that her neighbours called her '*shushushu*' (a spy) because she never participated in any of the community gatherings but always had information about everyone and everything. When I began to formulate this research project, Theresa was the first person I thought of; and when I began my research in June 2019, I contacted her via WhatsApp and she agreed to participate.<sup>8</sup>

Next, I contacted Halima. Halima is a licensed pharmacist working at the pharmacy in Mbezi Afrikaana, a neighbourhood in a suburb of Dar es Salaam. The pharmacy is located opposite a car wash, and sits alongside a clothing store, a bar, and a supermarket. I first met Halima in 2015, when I stopped by her pharmacy to buy some medicine for my mother. Over time, her establishment became our family pharmacy, the only place where we bought our medication. Given the relationship we had built over time, I was almost certain that Halima would be willing to help me with my research too. When I reached out to her, she agreed to participate without hesitation.

Jane, the owner of a hair salon, was the third woman I contacted. I was introduced to Jane by my cousin, a client of Jane's for many years. Jane's salon is located in one of the busiest working-class neighbourhoods in Dar es Salaam, Sinza Palestina. She built her salon inside an intermodal container, a common practice for many business owners in the city because such containers are affordable and mobile. Jane explained to me that by building her salon in the container she only had to pay the landowner rent; if they got into any disputes, she could easily leave with her salon intact. The day I met her, I went to get my hair done. The whole process took about three hours but felt like less, mainly because Jane filled the room with stories of her life, her family, and her community. The salon was packed with women coming in and out, not only to have their hair done but also simply to sit and listen to her stories.

I reached out to other potential informants but being met with no interest I decided to stop the recruiting process. However, one day when I was interviewing Jane at

<sup>8</sup> As part of the informed consent process, I provided all four women with information about the study, a description of what I hoped to achieve, and a copy of the informed consent agreement and the interview items. I ensured that they knew their rights throughout the process of fieldwork and I was transparent about how I would use the data I collected, including that I hoped to make the findings readily available as well as accessible to the research participants for their own use.

her hair salon, I met a woman named Nusra. Nusra showed great interest in my research, at times also answering the questions I was asking of Jane. After I explained the project to her she also agreed to participate. Nusra worked for a cleaning company in a part of Dar es Salaam called Msasani Peninsula.

I followed these four women as they went about their day-to-day activities, including observing them in their workplaces and accompanying them when they ran errands. I conducted qualitative interviews with them in Swahili, the national language of Tanzania and my first language. With their permission, I audio-recorded the interviews then transcribed and eventually translated them into English. It was vital to record the interviews in order to accurately represent the perspectives and stories of each participant, as well as to further capture the intonation, nuance, meaning, and sequence of our dialogues.

When conducting my fieldwork, I knew that I wanted to take a feminist standpoint. Exploring this research through a feminist lens meant taking account of the intersections of patriarchy and gender oppression that influence how gender and sexuality are experienced in Tanzania. Thus, when approaching my fieldwork and analysis, the process of questioning and deconstructing (Mbilingyi 1992, 46) was central. For instance, I began to deconstruct what it meant to be an African or Tanzanian woman. How is she characterised and homogenised? What are her life experiences? And how do these identities affect what she understands as fake or fake contraceptives?

Scholarly or policy discourses tend to homogenise social categories and treat all those who belong to a particular category as equally sharing its attributes (Mbilingyi 1992). Following on, one might then assume that all women in Tanzania negotiate access to contraceptives in the same manner. However, as Yuval-Davis (2006, 199) states, one needs to carefully differentiate between different kinds of differences. A post-structuralist feminist analysis might in contrast first entail exploring how identities are mediated. Sharp (2000) argues that reproduction renders the female body vulnerable to regulation and commodification, and that medical practices undermine women's agency over their own reproduction. as Sharp argues, in medico-clinical contexts power is asserted through technological hegemony (2000, 300). So how do women work towards regaining agency over their own bodies? What we find in the present study is that choosing to access contraception in the face of various social, political, and cultural barriers is one such way.

I followed a feminist methodology to provide space for the women in this study to speak for themselves and to recognise how they create knowledge through their lived experience. During the interviewing process, both parties shared and exposed parts of ourselves, which can be risky, as space for vulnerability opens

up. I was cognisant of the level of care and caution that is required when hearing people's stories. Ethical considerations are important in any fieldwork, but especially so when conducting research on sensitive topics such as this one.

In addition to the standard process of gaining informed consent, I sought to remain aware of these women's emotions, their bodily gestures and reactions to my questions. If at any point the interview seemed to be affecting a participant, for instance if they avoided talking about certain subjects, started to feel awkward, or were becoming emotional or uncomfortable, I stopped the interview. Because research participants shared social networks with me, were around the same age as me, and are women with whom I have interacted before, no one questioned my 'hanging out' with them, which made ensuring confidentiality easier to manage. We were inconspicuous, looking simply like friends going about their day.

## **Talking about side effects**

### **Biomedical side effects**

Side effects can be defined as the results of a medication on the body that are unrelated to that treatment's primary objective. It is recognised that how one experiences side effects can influence one's selection and use of pharmaceuticals (Kamat 2009, 295). For instance, in qualitative research among 30 adult patients from two general practices in London, Britten found that patients' aversion to medicines was due to a fear that medicines would cause harm to their bodies; they also named cancer as a side effect of pharmaceuticals (2002 cited in Whyte, Van der Geest, and Hardon 2002, 65). Similarly, Costa and Chaloub conducted an ethnographic study on the use of hormonal contraceptives in three Brazilian cities and found that 80% of women thought that contraceptive pills were harmful, and 60–70% reported side effects such as headaches, dizziness, and weight gain as major concerns (2002, cited in Whyte, Van der Geest, and Hardon 2002, 72). In her study on the circulation, appropriation, and use of synthetic hormones and related biomedical technologies Emilia Sanabria (2016) studies these medications and their relation to health, modernity, and Brazilian national identity. In Brazil, Sanabria (2016, 79) also found that the side effects of prolonged or suppressed menstruation resulted in women's suspicion about these medications.

Kaler (2003), for her part, has traced the development of modern contraceptives in pre- and post-colonial Zimbabwe and the ways in which these medicines have come to be understood, through broader conversations on gender, sexuality, power, and resistance in many domains of African social life. She explores how women react differently to these biomedical technologies: some welcomed them as ways to increase their bodily autonomy, while others resisted them, seeing them as an attempt by white colonialists to exert control over African women's bodies.

Side effects also influenced how the women in Kaler's study understood contraceptives. These were a concern, Kaler argues (2003), because women's sexual organs were the site where female morality and virtue were grounded, and thus bodily changes had implications for individual and collective morality. One of the main problems that women complained of when using contraceptive pills and injections was that these medicines caused their vaginal secretions to increase. Women also complained about headaches and weight gain and expressed anxiety over these medicines causing infertility. However, the most common problem mentioned by the women in Kaler's study was disruption to the menstrual cycle. Women who abandoned the medicines because of menstrual irregularity were spurred on to do so not only by the physical discomfort and ill-health these caused but also by the implications of changes in the menstrual cycle within traditional Shona body knowledge (Ibid., 91). For these women, having either too much bleeding or not enough was a concern because menstruation is regarded as a form of purification, cleansing the body of accumulated toxins (Ibid., 92).

The women in my research were similarly concerned about side effects. While their use of the term 'side effects' seems to be part of common medical discourse about hormonal contraceptives, it does not map exactly onto it. Instead of seeing side effects as an expected corollary to an effective medicine, these women saw them as indicative of a problem with the medicine itself, of it not working the way it should. This was precisely what made the medicine '*feki*'.

I began a conversation with Halima by asking her about 'fake' pharmaceuticals and whether she had ever had any experiences using these products. Working in the pharmacy, Halima said that she had never experienced *dawa feki*, but could understand why some people believed that there is a growing threat of fake pharmaceuticals in the country. Depending on where one is prescribed medications or where one accesses them, she told me, people may encounter *dawa feki*. She explained that some medications could be detrimental to a person's health, but that she was obliged to sell them when doctors prescribed them. She added that she has had patients who have reacted negatively or have become addicted to certain drugs and suggested that this is why certain drugs are understood as *feki*.

When it came to her own use of contraceptives, Halima expressed the fear that contraceptive's side effects would permanently damage her body. Irregular and prolonged menstrual cycles made her worry about infertility. Like Halima, most of the women believed that because hormonal contraceptives affected their menstrual cycles, and that they could make them infertile and even sterile. Here is how Halima described her concerns: 'Women take these pills until they want to get pregnant and then they realise they cannot. I know a woman who went to the



hospital to get checked and the doctors found contraceptive pills built up in her womb. ... Honestly, all contraceptives are bad for you’.

The fakeness of contraceptives was related not to whether they prevented pregnancy but rather to their side effects. Women maintained that the more severe the side effects were, the more likely the hormonal contraceptives were *feki*. Thus, the term does not denote the inefficacy of the drug itself but rather points to the complexities of how women navigate their use of contraceptives. Calling contraceptives ‘*feki*’ makes it clear that women do not consider them as entirely safe and proper to take and somewhat displaces the discomfort that comes with taking them.

### **How to know about side effects**

Some of the side effects women worried about aligned with those found in biomedical discourses. However, other concerns were influenced more by social and cultural ideas about their bodies. As mentioned above, fear that hormonal contraceptives would lead to irregular menstrual cycles and lessen their capacity to bear children stirred up feelings of distress amongst the women.

My conversation with Jane about ‘*feki*’ drugs began in her salon as she was having an argument with another hairdresser about whether a woman should stay with a cheating man. According to Jane, ‘all men cheat’. I piped up: ‘If all men cheat, then what should you do to protect yourself? Should you use contraceptives?’

She looked at me with a stern look on her face and said ‘No! Only if you’re married’. ‘Do you use contraceptives?’ I asked. ‘Am I married?’ she responded. According to Jane, only married women should use contraceptives because unmarried women don’t engage in sexual activities as often, and therefore, their chances of getting pregnant are lower. As the conversation went on, she connected her hesitation about contraceptives to bad side effects, saying, ‘they work but they give you problems. They will affect your body’. Jane warned that hormonal contraceptives have long-lasting negative effects on the reproductive system and can cause serious, irreversible illness. She declared that even if one stopped using hormonal contraceptives, ‘you can experience these problems for almost a year because the poison is still circulating in your body’. She also connected her own experience of irregular menstrual cycles to the possibility of getting fibroids: ‘The point of contraceptives is that you get your period. But you don’t get your period, and that’s when you get fibroids. Where do you think all these fibroids come from?’

Similarly, Theresa spoke of going to a *duka la dawa* to get contraceptive injections, which her friends told her was the best method to avoid pregnancy. However, she soon after started noticing various effects. After experiencing cramping she decided to stop getting the injections. She explained: ‘People say you shouldn’t

use injections; they will bring you problems and you'll get cancer. So, I stopped. Because I wouldn't get my period, and when I stopped getting the injections, I would have my period for longer days. Honestly, all those drugs have problems, they're all *feki*'. Such statements reflect the idea that how a woman's body reacts determines whether a product may be *feki*.

Jane acknowledged that she had used various contraceptive methods, including hormonal injections, birth control pills, morning-after pills, and the transdermal contraceptive patch. According to her the intra-uterine device (IUD) is the least effective contraceptive method because, she believed, it can be dislodged when having sex: 'Your man can come out with it, in between his legs'. She therefore opted for the morning-after pill, although she still emphasised its side effects. She said, 'There are days when I have sex and, on those days, I count the days I'm supposed to have my period, or I use P2 [morning-after pill]. However, those drugs aren't good. That's why people get fibroids. They're supposed to tell us the effects of these drugs'.

Such ideas about both the female body and the side effects of contraceptives played an important role in how the women in my study viewed, understood, and negotiated contraceptive methods and whether they identified hormonal contraceptives as *feki* or not. For instance, Jane claimed she did not need contraceptives because she had sex infrequently and because pregnancy could be stopped by other means:

I don't have a husband. I have sex once a month, why do I need contraceptives? Either way, even married women don't always use contraceptives because they're bad for you. You don't need to take contraceptive pills to stop pregnancy. There's cold water. You put cold water in the fridge. When you're done, you just need to drink two litres of cold water. Once you pee, the game is over! You'll never get pregnant in your life! There are people who live by that. They're people in their homes, all they have is bottles of UHAI [brand name for bottled water] and P2. A full box! When she's done, she drinks. It works!

Jane's understanding of medication is an embodied one. For her, there is no universal experience with medication: your own body is the best at identifying whether a drug is *feki*. She illustrated this giving me an analogous example, when she said:

If I get sick with malaria, I drink Metakelfin and I'm cured. But there are others that this drug affects them [badly]. It's not that the drug has problems, it's that they don't go with that drug. Their body doesn't react well with that drug, or their blood and the drug don't react well with each other. I get malaria and I

drink Metakelfin, but if you drink Metakelfin, you don't get cured and it brings you problems.

Similarly, Jane believed that if your body reacts negatively to hormonal contraceptives, as indicated by side effects, it is a sign that your body is rejecting the medication and it is therefore *feki*. Again, how the body reacts plays an important role in establishing the authenticity of medication.

Both the experiences of their own body and what they learnt from 'other women' influenced how the women came to understand *feki*-ness. Theresa's knowledge of hormonal contraceptives, from where to access them to the types of methods to use, was shaped by people in her community. She never received the necessary information from formal medical institutions and therefore relied on other women's advice and on how her own body reacted. Following her initially negative experience of injections, and after seeking advice from other women in her community, Theresa opted to stop getting injections. Although she wasn't given enough information about birth control pills, she nevertheless used them because 'people' advised her to. Various stories and shared experiences of contraceptives circulated, with the *duka la dawa* also filling the knowledge gap.

This is the nature of these stories: they do the work of telling people what they must look out for and what they should and should not do. Such stories also directed the women in the study to get their contraceptives from the *duka la dawa*. There is a degree of trust built into these social networks, one that counters the lack of access to formal medical advice and social pressure to not use contraceptives. The messages passed through their social networks functioned as advice, counsel, and alerts for women, allowing them to gain greater control over their fertility.

### **Social side effects as moral commentary: Striving to be *halali***

In describing their use of contraceptives and how they thought contraceptives should work, these four women further engaged with ideas about identity, and specifically with what it means to be a Tanzanian woman. They did not want to lose the 'normality' of regular menstrual cycles and the capacity to bear children. Nusra was concerned about irregular cycles and her inability to get pregnant, which she blamed on years of hormonal injections. This shaped how she viewed herself and her role in her community. The idea of not being able to bear children stirred feelings of distress in her and the other women. This is what I mean by 'social side effects'. Using the concept of *halali*, Nusra explained how a woman is supposed to behave in marriage: 'The joy of being a woman is that you stay home, and you let your husband take care of you. Your job is to keep a nice home, a

place where you and your husband could be proud of. Then people will see you as being truly *halali*!

This idea of a '*halali*' or legitimate Tanzanian woman came up many times in my discussions with participants, all of whom emphasised the importance of being a mother. For these women, fertility is not only a woman's biological duty but a moral responsibility too, thus influencing a woman's social status and acceptance in society. In this framing, a *halali* Tanzanian woman is a woman who does not use hormonal contraceptives; if *halali*-ness is about moral purity and conduct, then the use of contraceptives is seen as straying from this identity. These women spoke highly of this identity, wanting to achieve it by any means possible. However, much to my surprise, they still (secretly) used hormonal contraceptives. Their secrecy was driven mainly by external factors, as social, cultural, and economic constraints propelled them to limit their fertility even though they did not necessarily want to.

Theresa understood reproduction as a biological duty and believed that any woman who did not fulfil her duty would have 'bad luck'. She noted: 'It is not right not to have children. You have to have children; you don't just exist and live in this world by yourself. It's not right. If you say you don't want children, it means that bad things will happen in your future'. For Nusra, childbearing was not only a biological duty but a spiritual one too. She explained that childbearing is a duty given to women by God for the betterment of society, and that therefore it was important for her to achieve it. In her view, contraceptives could forever thwart this goal. As Nusra went on to exclaim 'Children make you happy! You never know what God has planned for you, how many eggs you have inside you. What if you only have one egg and you get an injection? That's it! You don't have a child. There goes your womanhood. What are people going to say?'

These women's desire to have children was influenced by their desire to be accepted by their communities. Halima experienced complications during her first pregnancy, which resulted in a stillbirth. Describing it as a 'difficult journey', she described being ostracised by her community:

My child had died two weeks in my stomach and people knew. I didn't go to the hospital for two weeks. You need a lot of heart to go through that. You know, people would run away from me. Everyone in my family knew. I couldn't hide it. I just had to go to sleep, wake up, continue with my day, knowing that my child had died. It was hard but you just have to thank God.

To reclaim her identity as a *halali* woman and her role in society, Halima needed to have children. Fortunately, she was able to regain the respect of her family and her community when she gave birth to a son, a year later.

I want to emphasise that the women in my study recognised the constructed roles and beliefs about *halali* womanhood within Tanzanian culture and understood that this identity was deeply rooted in their ability to reproduce. Furthermore, their reproductive bodies, and their reproductive successes or failures, were a concern not only for them but also for their partners, families, and communities at large. The fear of being shunned as a result of their inability to bear children was a huge concern, and they were therefore committed to fulfilling their roles as mothers.

What became clear through this research was the social process of stigma surrounding women's sexual and reproductive health in Tanzania. The reality for these women was that they used hormonal contraceptives, despite the fact that (*halali*) women in Tanzania are socially constructed as not doing so. In other words, taking hormonal contraceptives made it impossible to be a *halali* woman in principle. Furthermore, having children is conceived as an important duty to ensure one's belonging in one's community. Given this context, we can understand the fear of being morally ostracised as a social side effect.

### **‘You can never say you don’t want children’: Living the contradiction**

In Tanzania, having many children increases men's social status in their communities, and it is widely assumed that women have an obligation and responsibility to provide men with children. Nusra put it plainly: ‘When you get married, it doesn't matter if you have children already, you have to birth a child for him’. According to the women I interviewed, their men valued children because they brought honour to their families. Children are born into the male ancestral lineage, and therefore carry the name and the legacy of their lineage. For instance, in the Meru tribe of Tanzania, the family name and property is carried through the male line, from father to son. It is the son who inherits the homestead or household and who must then manage the finances (Butovskaya, Burkova, and Karelin 2016, 146). Women's reproductive successes or failures are a concern then, not only for the women themselves but for their partners and both sets of families too.

In my research, some of the women felt they had little choice over their own reproductive futures because they were beholden to their husbands' wishes. For instance, Nusra spoke about what men expect from marriage:

You can never say you don't want children. You get married and you have to give your husband a child. A man can never accept for you to just live with him and not bear him any children—maybe if he has other children outside the marriage. [But] What kind of love is that? Your husband won't even love you because you'll just be living with him. You don't love him, that's why you don't want children. How are you going to live? He married you and *kakuweka ndani*

[it's a married woman's duty to stay in the house as she now belongs to her husband], you have to bear him children.

Jane echoed these sentiments, explaining that men have power and control over the marriage and are therefore the deciding force in the relationship, even deciding to leave if they want:

Men have the strength to say whatever they want. They have the power. Women are nothing to them, that's why he can have children with you and another woman and another. And if he pays *mahari* [bride price] for you, and if it's a lot of money, you'll enjoy life, but you have to have children. Otherwise, he'll go somewhere else and you will be replaced.

While Jane thought it imperative that a woman be in control of her own fertility, she also recognised the gender constraints that exist in such relationships that grant women no autonomy or power over their own reproductive bodies. She advised that 'you should have two children of your own, and [then] secretly have hormonal contraceptives, even if he's like, "I'm gonna go have children with another women." Tell him to go. Because who's gonna have trouble raising those children, me or you?'

Still, refusing to have children was not an option for these women because it meant they were not fulfilling their duties as *halali* women. And so, instead of publicly losing this identity they used hormonal contraceptives, which in turn they described as *feki*. Characterising contraceptives in this way invoked not only the biological but also the social side effects they carried, which compromised them and made them dubious.

Various social and economic constraints made it necessary for the women to use contraceptives, regardless of whether they believed them to be *feki* or not. Although they did not condemn their men, or speak out firmly against patriarchy, what came in for strenuous criticism was men's behaviour in trying to control their wives' reproductive bodies. Men's control over their fertility was a source of stress for them. These women believed that the men in their lives did not treat them with the respect they deserved, often impregnating them then refusing to take responsibility for raising their children or to contribute financially to their family's expenses. As Jane explained, 'Men love to say, "Leave your work and have children", and then they leave you. How are you gonna take care of them?' Their husbands' inability to financially support their families meant that these women became the sole providers, running their own businesses and working in full-time jobs. While Theresa said that having children is an important aspect of a woman's life, she was also concerned about the cost of raising children and the obstacle

pregnancy posed to working and earning money. It was these challenges that prompted Theresa to use hormonal contraceptives.

Financial constraints affected the quality of these women's lives and their ability to take care of their families. They gave examples of various jobs that Tanzanian women might do in order to feed their families. Jane spoke of prostitution as an activity that many women take up in order to deal with financial pressures:

Women go sleep with other men, working in bars because they have to take care of their families. I know a woman who sleeps with the pastor at her daughter's school just so her school fees could be paid off. This woman is married but her husband doesn't take care of his child. Life! A woman survives using her body!

The lives of the women in my study were filled with attempts to subvert their husbands' claims on their bodies. While having children is an important part of their lives and fulfils their identities as *halali* women, they encountered constant challenges from men who abandoned their responsibilities as fathers and providers. Further, having more children than they could afford to take care of was also a threat to their identity as *halali* women. This bind too caused women to turn to hormonal contraceptives as a way of exercising control over their reproductive bodies.

However, it was difficult for these women to maintain their *halali*-ness when accessing formal medical care. Obtaining contraceptives from healthcare facilities or official pharmacies meant having to share information or seek their husband's consent. They wanted to keep their medical and sexual history hidden, and visiting the *duka la dawa* allowed them to do so. As Theresa explained:

To get an injection in a public hospital is free, but that means you have to answer the questions they ask you. They ask you about your husband, if you're married, if he knows you're getting contraceptives, or how many boyfriends you've had. Only if you answer those questions correctly will they give you the injection, so instead I go to a *duka la dawa*.

For these women therefore, reproductive health, though deemed important, was valued less than the need to maintain secrecy. The process of accessing contraceptives thus entailed both negotiating biological and social side effects and learning how to preserve secrecy in order to maintain a *halali* identity.

## Conclusion

Given this layered picture of *halali* ideals, social pressures, and everyday challenges in caring for a family, we can return to our analysis of women's complex

attitudes toward contraception. The women in my study sought to avoid both ‘social side effects’ and their husbands’ claims on their bodies and resources. Being seen as *halali* gave them a sense of belonging in Tanzanian culture, and having children solidified their identity and signified their membership of their communities. However, various social and economic constraints made it difficult for them to refrain from using contraception, as *halali* women are expected to do.

Although their husbands did not necessarily take responsibility for their children, it did not stop them from having power over, and controlling, these women’s fertility. The gender roles in their relationships meant that the men had overriding control over their women, who had no freedom to express their wants and needs especially when it came to reproduction.

This is where the notion of *feki* comes into play. A drug’s *feki*-ness has nothing to do with its efficacy. Rather, it is an expression of the contradictory lives that these women live. On one hand, taking contraceptives disrupted their identity as *halali* women; on the other, using contraceptives offered them a degree of autonomy and agency over their reproductive bodies. By dismissing these drugs as ‘*feki*’, the women could hide the knowledge they had of hormonal contraceptives, as well as the fact that they were using them, from their husbands, families, and communities. Ascribing meaning to these drugs based on their own experiences and those of other women, visiting a *duka la dawa*, and identifying drugs as *feki*—all these combined allowed these women to keep intact their social identities, projecting a ‘*halali*’ identity while retaining agency over their reproductive health.

## Authorship statement

I am the sole author of this work.

## Ethics statement

This research received ethical clearance from the SOSS Human Research Ethics Committee of the Department of Social Anthropology at the University of Witwatersrand in May 2019.

## Acknowledgements

To my family, thank you for everything. There is a special place in my heart to the women who participated in my study. Thank you for trusting me with your stories.



Without your incredible strength and support, this research would not have been possible. Thank you to my Masters and PhD supervisor, Julia Hornberger for the guidance and endless support. To my colleagues in the ‘What’s at Stake in the Fake’ project, thank you for your support and encouragement. Erin Martineau, thank you for the comments and incisive feedback during my critical writing phases. Lastly, thank you to the editorial team at MAT and peer reviewers for the clear and helpful comments. This research was supported by the Wellcome Trust-funded project ‘*What’s at Stake in the Fake*’.

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