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Secret strategies: Women and abortion in Yoruba society, Nigeria

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INTRODUCTION

Study rationale

Why do so many women like Toyin die from abortion, unnecessarily? Why don't women have safe abortions, or better still, why don't they prevent unwanted pregnancies? In this book I want to uncover the many complex, intertwined motivations and contextual factors that influence Yoruba women to not use effective contraception and to resort to risky practices of unsafe abortion.

My interest, or rather *drive* to conduct an applied anthropological study of abortion stems from my work for health programmes in a number of African countries since 1985, including Nigeria, Zambia, Ghana and Kenya. I was shocked by the many stories about women dying of induced abortion, especially those of young girls still in school.

I come from the Netherlands, a country where most women (and men) prevent unwanted pregnancy by using effective contraception, where most youths start using contraceptives when they begin to have sexual relationships, where premarital sex is more or less accepted by most people and where abortion is legal, accessible, and safe. I have seldom heard of a woman dying from abortion in the Netherlands.¹ The situation in most African countries is very different: abortion is illegal and abortion services unavailable, inaccessible or unsafe. When African women are confronted with an unwanted pregnancy, they have to make the difficult choice between keeping the baby and facing the social and economic consequences, or finding a way to induce abortion and face the risk of suffering from serious health consequences or dying. Why do these women opt for such hazardous practices? Illegality of abortion does not seem to be the only reason that women resort to unsafe abortion, as I also heard similar stories in Zambia where abortion is legal on most grounds.

Overall, I found that Africans had little sympathy for women who had aborted and suffered complications. When talking to women, men and youths about induced abortion, most of them would usually shake their heads and say that it was something very bad. They considered it to be the woman's own fault if she had problems, because she had been foolish to have an abortion and even

more so for having an unwanted pregnancy in the first place. Yes, I thought, one *should* prevent an unwanted pregnancy, but of course that advice is of little use once the pregnancy is already established.

The low contraceptive use and the high abortion rate in many African countries have long puzzled me. Do women prefer abortion to contraception? Are contraceptive services less available or accessible than abortion services? Do women realise the risks they take by having unsafe abortions? The answers to these questions might provide the key to unlocking solutions for the problems resulting from unsafe abortions.

In my previous work in Africa, I was involved in several action-oriented studies of the problems related to unplanned pregnancy, abortion, contraception and maternal mortality. The study methods we used consisted of surveys in the form of one-time interviews and focus group discussions. I always had the uneasy feeling that the information collected was not sufficient to design *optimal* interventions for the specific groups of women. I blame the use of this methodology mainly on time constraints imposed by the tight deadlines and the established protocols of our studies. Research time competed with time needed for other assignments; there was no leeway to explore different study methodologies based on earlier findings. I therefore wrote a proposal for an extensive applied anthropological study into the problems of induced abortion among one ethnic group, Yoruba of Nigeria, in which I wanted to explore participatory data collection methodologies.²

Statement of the problem

Estimates, mainly based on studies in hospitals, calculate that as many as 200,000 to 500,000 pregnancies are aborted annually in Nigeria and that 10,000 women die from abortion-related causes each year (Renne 1996:485). These abortion-related deaths greatly contribute to the high maternal mortality figures in Nigeria; reports indicate that 35% or more of maternal deaths are due to induced abortion (Okonofua et al. 1992:75; Royston & Armstrong 1989:110).³ Obtaining reliable figures on abortion is problematic, because the secrecy, illegality and privacy surrounding abortion make studying it difficult.

Induced abortion in Nigeria is illegal unless it is done on medical grounds, in order to save the life of the pregnant woman. This law does not seem to inhibit women from aborting; nor does it prevent abortionists from offering their services. The illegality of abortion means that public hospitals officially perform abortions only on medical grounds. Women who want to abort for other reasons must go instead to private hospitals, clinics and possibly other providers, where the abortionists are committing a criminal offence. The illegality of all

abortions outside public health institutions means that there are no official quality control procedures and that substandard abortion clinics can, and do, thrive (Okonofua et al. 1992:78).

Yet, not all the illegal abortions are by definition unsafe; some illegal providers may offer safe abortion services. Reasons why women have unsafe abortions may well be other than the illegal status of abortion and the abortion services' context. Women's socio-economic and cultural environment as well as personal characteristics, such as educational level and marital status, may influence women's motivations to resort to unsafe abortions instead of safe ones. Programmes to alleviate the abortion health risks can only be successful when they take into account all of the possible factors that influence women to have unsafe abortions. Until now, studies to uncover all of these factors have been absent in Nigeria. Before presenting the research questions that will be answered by the present study, I will review the literature on abortion and contraception, focusing in particular on that in Nigeria.

Induced abortion

Definitions

Abortion is the termination of a pregnancy before the foetus has become capable of independent extra-uterine life. According to the biomedical tradition, this covers the first 28 weeks of gestation, as counted from the first day of the last normal menstrual period. An *induced* abortion is characterised by deliberate interference with the pregnancy, either by the woman herself or by someone else, with the aim of terminating it (Royston & Armstrong 1989:107). An induced abortion in the first trimester and performed by a qualified person under hygienic conditions constitutes less of a health risk than carrying a pregnancy to term and delivering a baby (Coeytaux et al. 1993:136; Lin et al. 1999:114; World Health Organization 1993:4). Unfortunately, many women have unsafe induced abortions, in particular in developing countries, and end up suffering serious complications including infertility and death. The WHO defines *unsafe abortion* as 'a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both' (World Health Organization 1996:60). Further terminology related to abortion include: *abortion rate*, defined as 'the number of abortions per 1,000 women of reproductive age'; *abortion ratio*, 'the number of abortions per 100,000 live births or pregnancies'; and *abortion mortality ratio*, 'the number of abortion deaths per 100,000 live births' (World Health Organization 1993:9).

The global picture

As early as 1967 the World Health Organization recognised unsafe abortion as a serious public health problem, although at that time only limited information was available on the extent of the problem. Since then, several researchers have conducted studies on abortion. However, they were often constrained by lack of funding because of donors' unwillingness to fund research on such a sensitive topic (World Health Organization 1996:4). Thus, due to this scarcity of studies as well as the difficulty of arriving at representative findings due to the limitations of most studies that have been conducted, figures on abortion incidence and prevalence are inevitably crude. The World Health Organization (Indriso & Mundigo 1999:23-24) estimates that each year around 30 million induced abortions occur, of which 20 million are unsafe and 70,000 result in death. As most of the unsafe abortions (90%) occur in the developing world, it is no surprise that the risk of dying from abortion in the developing world is 1 in 250, while it is only 1 in 3,700 in the developed world. The highest rate of case fatality is in Africa, with 1 death per 142 induced abortions (compared to 1 per 1,000 in Latin America).

Legality of abortion ranges from prohibiting it altogether to providing abortion upon request. Where abortion is generally available, laws usually regulate it as a medical procedure, while in places where abortion is criminalised it is usually addressed in the penal code. Even where abortion is prohibited, there may be supplementary allowances for abortion on 'judicial grounds' when a pregnancy is the result of rape or incest. Some countries also permit abortion on 'foetal impairment grounds' when there is a strong probability that the foetus has developed or will develop a serious anomaly (Rahman et al. 1998:56). Rahman et al. (1998:58) cite figures from the Centre for Reproductive Law and Policy that show that 39% of the 191 countries in the world prohibit abortion altogether or only to save the pregnant woman's life and that 26% have the most liberal abortion laws. In sub-Saharan Africa only two countries have liberal abortion laws: Zambia allows abortion on social and economic grounds and South Africa without restrictions.

Rahman et al. (1998:56) foresee a global trend towards the liberalisation of abortion. Evidence from around the world shows that more permissive abortion laws reduce morbidity and mortality. However, more liberal laws are not a guarantee for reduction of morbidity and mortality; abortion services may be more accessible and safer in countries where abortion is illegal, but where the law is not enforced. They therefore warn that 'women's ability to obtain abortion services is affected not just by the law in a particular country, but also by how these laws are interpreted, how they are enforced and what the attitude of

the medical community is towards abortion'. Researchers point out that in countries where abortion is legally permitted, but specifying conditions such as gestational age, permission of husband or parents and type of facilities or medical practitioners to perform the legal abortion may all render services unavailable to many women. Such is the case in countries like Zambia and India. On the other hand, in a country like Bangladesh in which abortion is prohibited, the euphemism 'menstrual regulation' may be used and thus methods to induce menstruation up to eight weeks after the last menstrual period are allowed (Jacobson 1990:16-17; Rahman et al. 1998:57-59).

Abortion in Nigeria

Legal status

Nigeria is one of the 54 countries in the world that has very restrictive abortion laws. Abortion is a criminal offence and only allowed when it would save the life of the pregnant woman; there are no exceptions allowing abortion on grounds of incest, rape or foetal impairments. Under section 228 and 229 of the Nigerian Federal Criminal Code it is stated that 'any person who uses force on a woman, or causes her to take a poison or other noxious thing with the intent to procure her miscarriage is guilty of an offence punishable with 14 years of imprisonment' (Ilumoka 1992:88). The same penalty applies to the woman who aborts her own pregnancy. A woman (or her family) therefore is not likely to report a quack abortionist who caused her serious complications because the woman is a participant and liable to punishment herself. Yet, the Nigerian anti-abortion law is unclear and seldom invoked (Ilumoka 1992:96). This is unlike the situation in, for example, Nepal, Chile and Namibia, where women who are found to have aborted are actually imprisoned.

Many medical practitioners in Nigeria acknowledge the problem of high abortion mortality and plead for the legalisation of abortion; they argue that this would contribute to safer abortion services. These health professionals follow the standpoint of the WHO that recommends legalisation. WHO research shows that legalisation of abortion does not result in increased abortion rates, but instead change the conditions under which abortions are performed. Legalisation would mean a greater availability of safe procedures performed by trained health personnel (Indriso & Mundigo 1999:24). In 1974, the Society of Gynaecology and Obstetrics of Nigeria made the first unsuccessful attempt to reform the anti-abortion law. After that, in 1991 the then Federal Minister of Health Professor Olukoye Ransome-Kuti proposed a reform of the abortion law, but this was also rejected. In 1995 the Nigerian Medical Association en-

dorsed a reform of the law, but to date abortion is still illegal on most grounds (Henshaw et al. 1998:163).

Although abortion is illegal, many Nigerian physicians recognise the need for safe abortions and offer their skills to perform these services (Rahman et al. 1998:61-62). These physicians may interpret their services as being legal when they perform dilatation and curettage (D&C) as the only way to save a woman's life after she has taken an overdose of medicines or other substances in order to induce an abortion (see also Renne 1996:490). This is in contrast with, for example, the situation in Chile (which has some of the most restrictive abortion laws in the world), where the hospital staff would report such a woman to the police.

Abortionists

Researchers agree that most abortions in Nigeria are performed in private hospitals; other abortion providers are chemists, traditional healers, midwives and back-street abortionists (also known as 'quacks'). Women themselves also use methods for self-abortion. A community-based study by Okonofua et al. (1996:14) in Jos (Plateau State) and Ile-Ife (Osun State) revealed that 79% of the women who had had abortions had them in private clinics, performed by private doctors. Likewise, a national community-based study conducted by the Campaign Against Unwanted Pregnancy (1996:3) discovered that 78% of abortions were performed in private clinics. The percentages of women who resorted to self-abortion were 13% in Okonofua's study and 4% in the study of the Campaign Against Unwanted Pregnancy (CAUP). In a nation-wide survey of private and public health facilities performing abortion and treating abortion complications, Henshaw et al. (1998:161) found that 27% of private hospitals said they performed abortion occasionally.⁴ These researchers calculated that nation-wide more than 1,300 private hospitals, clinics and private practices perform abortions, of which more than half (700) are in the Southwest of Nigeria, which is Yoruba area. They also concluded that in approximately three-quarters of the hospitals and clinics, the physicians who performed the abortions were non-specialist general practitioners (Henshaw et al. 1998:159).

Concerning the safety of procedures, Henshaw et al. did not indicate whether abortions performed by the providers they researched were unsafe. Ilumoka (1992:91) doubts the safety of abortions in private hospitals because, according to her, the abortions are usually performed quickly and secretly, and no follow-up visits are arranged. In their study of abortion complications presented in a hospital in Ile-Ife (Yoruba area), Okonofua et al. (1992:78) support this claim. They state that, contrary to popular belief, physicians in private hospitals cause many of the complications, and that they are often not certified in

obstetrics and gynaecology. Caldwell & Caldwell (1994:291) attributed the high numbers of unsafe abortions to a lack of qualified and experienced doctors (without stating what they deemed 'qualified'). They reasoned that because of the illegality of abortion, doctors do not get the chance to practise it on significant scale.

Prevalence

The range in estimates of the prevalence of abortion is enormous, which is not surprising considering that an illegal practice such as abortion is difficult, if not impossible, to measure. Renne (1996:485) estimated that between 200,000 to 500,000 abortions are performed annually in Nigeria. Henshaw et al. (1998:159) estimated there to be as many as 610,000 abortions annually, of which 279,000 were in the Southwest, which is Yoruba area. They calculated an annual abortion rate of 25 per 1,000 women nationally, with the highest rate of 46 per 1000 women in the Southwest (Henshaw et al. 1998:161).⁵ Most of the researchers extrapolate the national abortion figures from hospital-based studies where women with complications due to abortions have been interviewed.⁶ For example, Henshaw et al. (1998) infer national abortion prevalence from data of a survey of private and public health facilities performing abortion and treating abortion complications. They assumed that half of the abortions performed by other providers (i.e. other than public and private health institutions) would end in complications that would present in the hospital. These figures are very crude, because the assumptions are based on reports of medical doctors and moreover, the assumption that all abortion complications would present in the hospital is most likely false (see also Coeytaux's commentary on limitations of hospital-based studies 1988:187).

Okonofua (1993:8) analysed the findings of various hospital-based abortion studies in Nigeria in order to estimate the induced abortion mortality ratio. He found figures that ranged from 31 to 178, the upper level being among the highest estimates reported in Africa (see also World Health Organization 1993:13-36). The reasons for the high abortion mortality in Nigeria, according to Okonofua, are the illegal status of abortion, the poor access to and quality of medical facilities to treat complications of abortion and the wide array of people who carry out unsafe abortion. Thus, Okonofua considers mainly service factors as responsible for the high abortion-related mortality in Nigeria, and does not consider other factors influencing the decision making process of women, such as care-seeking behaviour and socio-economic background of women.

Only a few community-based studies exist that address the prevalence of abortion in Nigeria and Yoruba society. Orubuloye (1981:85) found in his 1975 survey among women aged between 15 and 59 in a Yoruba village, that only

0.3% had an abortion. He also cited Morgan's survey of 1968 in Lagos in which 2% of women reported having ever undergone an abortion. Orubuloye admitted that these figures are likely gross underestimates. Olukoya (1987:43) conducted a study in 1982 in a peri-urban area of Lagos. Among 369 randomly selected women who had at least one child, 5.6% reported they had had an abortion. She concluded that this figure is an underestimate because women would have underreported due to the illegality of abortion and because the study naturally only included those women who survived. Makinwa-Adebusoye (1991) conducted a study on pregnancy and abortion among a sample of 2,796 female and 2,803 male youths aged 12-24 years, in five Nigerian cities including Lagos. She calculated that 39% of sexually active girls had been pregnant and that 16% of these girls aborted their pregnancy (Makinwa-Adebusoye 1991:46).⁷ Caldwell & Caldwell (1994:286) reported in their 1973 study in Ibadan (Yoruba area) that only 2% of the 6,606 interviewed Yoruba women between 15 and 59 years of age reported that they ever had had an abortion. In her recent study in an Ekiti Yoruba village, Renne (1996:486) found higher abortion prevalence. Of 300 women between 15 and 49 years of age interviewed, 21% said to have used abortifacients and/or had a D&C; in the 15 to 19 years age group this figure was 20% and within the ages of 20 to 24, it was as high as 36%.

Differences in prevalence figures between the studies may be related to the study methods and the study population, but they may also very well be related to the year of the study. In that case, these studies would indicate an increasing in the prevalence of abortion. In fact, according to Caldwell & Caldwell (1994:276), anthropologists concur that in the past abortifacients were widely known, but that level of practice was low.⁸

Women aborting

Most researchers agree that in Nigeria more and more girls and young women, and among these groups especially schoolgirls, are aborting their pregnancies (Akingba 1977 in Royston & Armstrong 1989:122; Caldwell & Caldwell 1994:282; Renne 1996:486). Caldwell & Caldwell (1994:287) explain that so many schoolgirls and young women are resorting to abortion these days because their ambitions now lie outside of the traditional sphere of the village or the extended family where marriage and having children provided the major indicators for social status. Additionally, the age of first sexual contact has decreased, while the age at which girls marry has increased; this gives girls more time to be exposed to the risks of premarital pregnancy.

Studies in other African countries also found that abortion is most common among single girls and women (see Bleek & Asante-Darko 1986 and Van den Borne 1985, for Ghana; Koster-Oyekan 1998, for Zambia). However, this may

not be the same all over the world. Henshaw & Morrow (1990, cited by Paiewonsky 1999:136) even concluded that in most developing countries women who obtain abortions are typically married with children. A WHO report on abortion likewise states that in developing countries, 'Contrary to common belief most women seeking abortion are married or live in stable unions and already have several children' (World Health Organization 1993:2).

Although researchers found that most abortions are performed on single women in Nigeria, several studies indicate that married women also abort. Coeytaux (1988:187) has even warned against focusing only on the problems of young girls. Jacobson (1990:36) found that in Nigeria, 30% of complications from abortions were reported in women over 25 years old, of whom one quarter had two or more children. A report of the CAUP (1996:1) on women who came to a hospital in Ibadan (a city in Yoruba area) with abortion complications confirmed that 30% were married women. Caldwell & Caldwell's (1994:286) community-based study in Ibadan found that 26% of abortion seekers were married. They indicate that in the context of Yoruba society, abortion by a married woman is frowned upon because she denies her husband's patrilineage a child already conceived (Caldwell & Caldwell 1994:274). They also explain that married women may abort because the child was conceived too early after the previous one, which would be proof of her having irresponsibly broken the traditional postpartum taboo (Caldwell & Caldwell 1994:284).

Moral aspects

Renne (1996:487) and Caldwell & Caldwell (1994:290-91) believe that Yoruba condemn abortion more because it threatens women's lives and reproductive health than they do because it is immoral. They explain this relative absence of moral objections in light of the perceptions of the development of the foetus and when actual life begins. Renne (1996:488) argues that Yoruba women in Ekiti have a preference for early abortion, not for the sake of the women's health, but because of the ideas about the stages of pregnancy development: the foetus is not really considered as a person in the early months. Some of her respondents believed that the 'real child' is formed sometime after the fourth month of pregnancy, while other Yoruba consider a child to be a person only eight days after birth, when the child is given a name.

This brings us to the question of how Yoruba women consider abortion. Is it a deliberate method women use to control their fertility as Otoide et al. (2001:80) and Renne (1996:483) suggest? Renne considers abortion among the Ekiti Yoruba as a pattern of behaviour in a continuum of birth control methods. In another article she theorises (1993:349) that abortion is more 'convenient' for some Yoruba women who want to secretly limit the number of chil-

dren. According to her, these women would rather risk a one-shot approach to fertility control with abortion than face the risk of being detected using contraception because women's use of contraception runs contrary to the gender ideology that dictates that men should make all decisions, including those about fertility regulation. Or do young women prefer abortion over modern effective contraception because women judge the risk of infertility through contraception to be higher than the remote risks of abortion on fertility, as Otoide et al. (2001:80) conclude from the findings of focus group discussions with adolescents? Do women resort almost automatically to abortion when they become pregnant after contraceptive failure because they are very motivated to control their fertility? Or alternatively, is abortion practised for other reasons, such as Pearce suggested, 'Abortion was practised mostly to prevent embarrassment, rather than to limit the size of families' (Pearce 1995:201).

Limitations in the abortion literature

As alluded to above, in most studies of abortion the sociocultural and economic context of the women who abort is missing. Studies of abortion, in Nigeria as in other countries, often aspire to give figures on the prevalence or incidence of abortion and consider use of (modern) contraception as one of the determinants. Exceptions in studies conducted in Nigeria are the aforementioned studies of Renne (1993, 1996) and Caldwell & Caldwell (1994). In a recent book on abortion in the developing world, which is a compilation of 22 studies (Mundigo & Indriso 1999), the women who had had an abortion were 'invisible' as social beings in most of the studies. Instead, these women were treated as 'cases' and in only a few of the studies did the researchers pay due attention to women's personal histories and analyse women's experiences in their socio-economic context, including the gender relations at different points in women's lives.⁹ Rylko-Bauer likewise observed these limitations in many abortion studies in her introduction to a special edition on abortion of *Social Science & Medicine*, which presented mostly anthropological studies on abortion:

Quantifying the extent to which women worldwide resort to abortion in the face of legal, ideological and economic barriers emphasises its pervasiveness, and the urgent need for reforms in reproductive health policies. (...) What is missing in much of the literature are the voices of women, their experiences and perceptions of abortion, the circumstances that shape their reproductive decisions, and the socio-cultural context so necessary to our understanding of the ideology, discourse and practice surrounding abortion at the local, regional, national and global levels. (Rylko-Bauer 1996:479)

One of the reasons for these shortcomings in most abortion studies may be that fertility and fertility regulation practices, including abortion, were initially the field of demographers. Demographers saw a unilinear development: modernisation (including schooling), availability of fertility regulation services and economic progress would cause persons to have fewer children, i.e. persons would make rational choices to limit their family size (see also Brand 2000:8-10). Greenhalgh (1995:12-17) was one of the scholars who first countered this unilinear model. She suggested that fertility regulating behaviour, if seemingly irrational in demographers' eyes, could be explained (i.e. be made rational) by situating it in the sociocultural and political economic context in which it is embedded. Greenhalgh pointed out that fertility regulation practices are surrounded by ambiguous notions. Certain fertility regulation behaviour may be good (rational) in a cultural and group-specific view, but may be bad (irrational) in health or macro-economic terms. She pleads for current research to aim at *situating* fertility and thus show how the many different fertility patterns make sense in the eyes of the actors. This is a goal of the present study.

Even in studies that do pay attention to the context of women who have abortions, the feelings and decision-making processes that women who want to abort an unwanted pregnancy experience are not fully explored. Additionally, the explanations of how certain perceptions, beliefs and structures in society make pregnancy, under certain conditions unwanted also scarcely receive attention.¹⁰ Some studies (for example Caldwell & Caldwell 1994) *do* identify the reasons for unwanted pregnancies differentiated by women's marital status, but it is assumed that abortion is a more or less automatic consequence of an unwanted pregnancy. Researchers picture women as calculated decision-makers without doubts or ambivalence. Moreover, they hardly pay attention to those persons whom women involve in their decision making, what women do once they have decided to abort and why they end up going to certain providers who may (knowingly or unknowingly to the women) be providing unsafe services. Still, knowing the sequences in abortion practices and understanding women's motivations to take certain actions is necessary for designing acceptable interventions to help reduce the incidence of abortion mortality and morbidity.

Contraception

The Nigerian National Population Policy

The Nigerian government only began to pay attention to family planning in the late 1980s, although some non-governmental organisations (NGOs) had

been working on family planning programmes since the 1960s. Pearce (1995:196-7) describes how in the 1980s the government realised the connection between population growth, high fertility rates and the nation's inability to make headway with development. Thus, in 1988, the National Population Policy was launched in order to control the population growth, which the government acknowledged as a problem when faced with decreasing oil revenues. Public contraceptive campaigns and services were (and still are) directed at married women. The campaigns encouraged women to limit their offspring to four children. (Men, who are often in polygynous relationships, were not given a recommended limit.) The Federal Ministry of Health with technical and financial assistance from the United States Agency for International Development (USAID), the World Bank and the United Nations Fund for Population Activities (UNFPA) distributed contraceptives to public and private health facilities all over Nigeria (Feyisetan & Ainsworth 1996:162). They expected that the population would widely accept the modern contraceptive methods.

Contraceptive prevalence

The Nigerian government's expectations of high contraceptive use did not materialise. Although usage has increased, especially among urban educated persons, it remains low. The UNICEF report *The state of the world's children* gives a national contraceptive prevalence of 6% for the years 1990-1999, calculated as the percentage of married women aged 15-49 using contraception (Bellamy 2000:110). The contraceptive prevalence for Southwest Nigeria (Yoruba area) is higher than for other regions. The 1990 Demographic and Health Survey (DHS) figures for this area state that 15% of married women currently used contraception versus only 9% in the Southeast, 2% in the Northeast and 1% in the Northwest (Bellamy 2000:110). Makinwa-Adebusoye & Feyisetan (1994:68) explain this elevated figure by saying that Yoruba are generally more highly educated than women in other regions, and that educational level has a positive association with contraceptive use. Statistics they give seem to support this hypothesis: 24% of married Nigerian women of secondary and higher education were using contraception. Recognising the positive association between educational level and contraceptive use, Ebigbola (1989:163-164) theorises that the success of the national family planning program is very precarious if the government does not at the same time address the problem of decreased formal school enrolment.

A limitation of these official contraceptive prevalence rates is that they do not reflect total rates, i.e. rates for the entire Nigerian population, because they are usually confined to married women or married couples. The calculation of

the unmet need for contraception is also usually based on married couples; the contraceptive needs of single women of reproductive age are thus ignored. Yet, the high figures on induced abortion among single women indicate that there *is* a need, and some figures indicate that the contraceptive use among single women might even be higher than among married ones. Feyisetan & Ainsworth (1996:16) cited the Federal Statistics Office's data that state that 13% of single women use contraceptives, while only 6% of married women do.

Reasons for low utilisation rates

Pearce (1995:197-198) argues that among Yoruba modern contraceptive use is low for two reasons. The first is that for many women and men the fertility *desire* remains high. Secondly, many women do not use modern contraceptive methods because they conflict with indigenous beliefs and practices. In the past, and to a much lesser extent today, large families made sense to secure a greater number in the family's workforce and because children (read: sons) secured survival of the patrilineage in the future. The members of the patrilineage thus had a vested interest in their wives having many children. DHS figures for 1990 indicate that the total fertility rate is still as high as 5.65 for Southwest Nigeria (Makinwa-Adebusoye & Feyisetan 1994:63).¹¹

Even if a Yoruba couple would like to limit their offspring or space children, men may often not want their wives to use modern contraceptives. Renne (1993:343-344) explains how the dominant male ideology states that the husbands should have the final say over contraceptive use of their wives. According to Renne, men believe that women are sexually weak and should not be allowed freedom of choice, because this will lead to extramarital affairs.

Another contributing factor to low use of contraception by all married women in Nigeria (and not only Yoruba) may be the fear of losing children. The under-five mortality rate in Nigeria is still high.¹² Nigeria is ranked 15th in the world for highest under-five mortality. For every 1000 live births, 187 children are likely to die before the age of five (Bellamy 2000:116).

Renne and Pearce explain the low use of contraceptives among Yoruba mainly by stating that Yoruba society is pronatalist and Yoruba men like to control the fertility and sexuality of their wives. Several studies in different developing countries (see Mundigo & Indriso 1999:57-198) tried to identify the reasons why women and couples do not use or discontinue using modern effective contraceptives, even though they *do* want to regulate their fertility. These studies pointed at various reasons both from services' and clients' side for the low use, but considered the main reasons for low use to be service-related: services do not respond adequately to the specific fertility regulation needs of their clients.

The studies conclude that most clients do not receive personalised counselling and information, are not free to choose a method and are denied access to the services (adolescents) or that the methods are of low quality.

Many studies of contraception suffer from the same shortcomings indicated in studies on abortion. Hardon (1997:68-69) rightly pointed to the limitations of demographic and epidemiological studies that usually do not consider the consumers', potential consumers' and non-users' views and motivations to use certain contraceptives. They also fail to examine how the interaction between health services and clients shapes these views and motivations. She states that most of these studies can explain neither *why* women do not use contraceptives nor why they discontinue to use contraceptives. Hardon stresses the important contribution of anthropological studies that cover precisely these subjects. Service factors may not be the only, or even the most important factors influencing non-use. Studies must look more closely at the motivations of women and men for not using contraceptives; it may be an active choice and not simply the result of structural (service-related) limitations. Women and men may find the contraceptives inconvenient. They may fear the side-effects, especially those that might impair their fertility. Their sociocultural context may also cause contraception to be unacceptable, for example, if husbands do not allow their wives to use them, or religion forbids any interference with God's intentions. Thus, only with a thorough understanding of the multi-faceted reasons why women do or do not use specific contraceptives, can family planning programmes succeed (Hardon 1998:136).

Study objectives and research questions

The general study objective was to explore the sociocultural, economic and service-related factors influencing the many abortion-related decisions of Yoruba women: to either keep an unwanted pregnancy or resort to abortion, the choice of method of aborting and the specific actions to take when abortion complications occurred.

To find out *why* women decide to abort pregnancies, the circumstances of an unwanted pregnancy have to be explored for specific groups of women. It is also important to examine the reasons why some women keep the unwanted pregnancy, whereas others terminate it. Once a woman has decided on abortion, she has to choose a provider and/or method for abortion. Other persons may well influence her decisions. Some women have safe abortions while others have unsafe ones. This choice may be out of ignorance or more or less deliberate. Unsafe abortions often result in complications that should be treated ade-

quately. Some women seek treatment immediately, whereas others, for a variety of reasons, may postpone getting help. Conducting applied research on induced abortion and unwanted pregnancy naturally leads one to wonder why women do not prevent unwanted pregnancy by using effective contraception or by abstaining from sexual intercourse. If contraceptive services are not available, accessible, acceptable or affordable, this may be the reason for women not using them, but there may be factors causing non-use other than service-related ones.

Translated into research questions the paragraph above reads:

1. What is the prevalence of unwanted pregnancy, of induced abortion and of unsafe abortion among Yoruba women?
2. Which circumstances make a pregnancy unwanted for Yoruba women?
3. Which factors influence the ways that Yoruba women cope with an unwanted pregnancy?
4. Which methods and providers do Yoruba women use for abortion and which factors determine their choice?
5. Which factors influence the ways Yoruba women cope with complications of induced abortion?
6. Which methods of contraception do Yoruba women use and which factors influence the decisions of Yoruba women either to use or not to use modern contraception?
7. What are culturally acceptable and feasible recommendations for interventions to reduce the number of (unsafe) abortions and the morbidity and mortality resulting from abortion?

Theoretical concepts

Rule and reality

Throughout this book I explore societal *rules* related to fertility regulation including abortion, as explained by study participants, including women, men, youths and health-service providers. I juxtapose these with the *reality*, or the practices and experiences of fertility regulation by individual women. The *rule*, in other words the dominant societal discourse about norms or ideal behaviour, is often different from the *reality*, i.e. the actual practices; many practices do not conform to the norms. This divergence between rule and reality poses methodological and theoretical challenges. How to design study methodologies that will expose both rule and reality? How to describe and explain the dialectical relationship between rule and reality? To phrase the question in language specific to this study: How does the societal discourse on abortion influence individual

women's abortion practices, and how do these practices possibly influence the discourse?

The discussion on the relation between rule and reality, or discourse and practice, has been relevant to anthropological studies for a long time. On a methodological note, as early as 1955 the Dutch anthropologist Köbben (1955:128) warned empirical researchers, against accepting general rules as representing behaviour without checking the rules against the reality of everyday life. He stated that informants, when asked 'what would you do when...' would usually give the rule and not the reality. Köbben (1955:139) advised that researchers would be better off *observing* reality, that is practices, than asking about them.¹³

Köbben's insights were very useful, but the methodological problem of how to study rule and reality has proven more intricate and ambiguous than even he suggested. Firstly, the reality cannot always be observed. Researchers usually cannot observe the reality of private practices such as those related to sexuality, as in this study of abortion. The privacy of abortion ensures that researchers must rely on what study informants report about their actions and practices; for various reasons they might not want to expose their true practices.

Secondly, scholars after Köbben argued that that which is observed is not necessarily the reality, but may be pretension to the public eye (see also Baerends 1994, Van der Geest 1975). Individuals or groups may show public behaviour conforming to dominant rules, but this may not be their *lived* reality, the reality as could be observed in private. Thus in these cases, reality is multi-layered: the practice that may be observed in public, the private reality and the subjective experience of the actors. In her study of gender relations in sub-Saharan Africa, Baerends pointed to this when she observed, 'The façade of subservience of women towards men should not be simply taken as a sign of subordination, but could be actually a part of the game in which women hold a certain amount of real power in exchange for paying respect to male authority in public'. She stated that there may actually be a considerable degree of equality between women and men, but that the compliance to the rule of male dominance is often the most profitable strategy for women (Baerends 1994:17-18).

A third challenge in the study of rule and reality is that there is usually more than one discourse in a society. Most present-day societies are more complex than the egalitarian peasant societies that Köbben studied; there are now multiple concurrent rules, dominant and alternative.¹⁴ In democratic and tolerant societies, alternative rules and practices may be easier to study, for individuals and groups are able to openly express their views and demonstrate that their reality runs against the prevailing rules of the majority. However, in intolerant societies, 'dissident' individuals and groups must keep their ideas and practices that oppose the dominant rules a secret; these groups are therefore more difficult to

study. Even if they are not explicitly oppressive, dominant groups may simply ignore the possibly divergent views of other groups in the public domain. Ardener (1975:xii-xiii) discussed such 'muted groups'. These groups publicly operate only in terms acknowledged by the dominant group's structure or rules of a society, though they may have their alternative models and behaviour. Women are one such muted group in many societies, as are youths and minority ethnic groups. These groups keep hidden views, actions and experiences that oppose the majority rules. Alternatively, they may have learned to express their views in other ways that are still tolerated by the dominant views of a society.¹⁵ Part of the challenge of studying the rules is to expose the possible alternative rules that may concurrently govern muted groups. The majority rule may be what is reported, but one or more alternative rules (of groups such as women or youths) may remain unspoken publicly, yet are in fact closer to reality.

Another reason why *the* reality is more complex than Köbben suggested is that social researchers nowadays realise that in addition to the various versions of reality of different groups in the society under study, researchers create their own version of it. The subjective position of the individual researchers, as it relates to their socio-economic, cultural, gender, theoretical and political backgrounds, conditions their view of the reality under study.

Rules and practices in a society are dialectical; they change and change each other over time (although according to minority groups, not always fast enough). Reality (actual practice) changes before the rules change. This often occurs generally and naturally, that is without ordinances about individuals' behaviour from 'above'.¹⁶ The alternative behaviour of a minority group in society *could* gradually change dominant norms. However, there are many more factors that influence a change in rules. Köbben (1955:173-4) already stated that the form and frequency of divergence from the rule might indicate a changing socio-economic and political context, thus identifying that the structure of society plays an important role in both rules and practices. Renne's (1997:173-174) study of contraceptive use in Zaria, North Nigeria is illustrative of the influence of contextual factors on changes in practices and rules. She theorised how endorsement of contraceptive use is in a process of changing from prohibition by the majority (male) rule to acceptance because of several social, economic and cultural 'contingencies'. She argued that while women use contraceptives secretly now because of the prevailing rules, these contingencies will gradually reassess, reinterpret and change the rules. An interesting challenge in this book is to expose the societal factors that influence change in abortion and other fertility regulation practices among the Yoruba that may (after a shorter or longer period of time) also change the rules pertaining to these practices.

Gender

The gender system is one of the societal institutions that influence women's abortion practices.¹⁷ Every society has its rules about gender relations that describe the dominant norms of appropriate behaviour of males and females. In Chapter 3 of this book, which deals with Yoruba society, I describe the societal role models of Yoruba women and men, particularly those concerning sexual relations and procreation. The existence of a gender system does not necessarily mean oppression of one gender by the other in all spheres of life, but in many societies, women are at a disadvantage in many domains as compared to men. Whitehead (1984:189-90, cited by Moore 1988:72) argues that especially in societies where bridewealth is paid, as it is in Yoruba patrilineal society, the family and kinship system often operates to construct women as a subordinate gender.

My initial position concerning gender relations was without assumptions about the existence of unequal gender relations in Yoruba society. This was partly because of professional motivations and partly inspired by the sensitivity in Nigeria about outsiders judging Nigerian systems (including, but not limited to, gender roles there). I read Nigerian scholars opposing Western feminists with their view of the global oppression of women (Amadiume 1987; Oyewumi 1997; Pearce 1995)¹⁸ and heard the same thing in informal conversations during past periods of living and working in Nigeria.

I acknowledge that some Nigerian scholars might be in a better position to understand their fellow women than Western researchers in *their* subjective position are. Pearce (1995:204) gives an example when she points out that Western scholars may interpret the terminal (sexual) abstinence of Yoruba women in conflict with female sexual rights. According to her, these scholars may fail to see that Yoruba women may very well not consider continued sexual activity as a privilege or something to be enjoyed, but rather welcome the culturally imposed terminal abstinence as a well-earned rest. The societal rules that impose terminal abstinence may suit women, albeit many women adhere to these rules for reasons other than those that the rules dictate.^{19, 20} Thus to conclude, as some Western scholars might do, that Yoruba women are passive (and subservient) followers of dominant rules, would not be reflective of the lived reality of women. Women may make an active choice to obey the rules, to suit their own purposes.

Some of the criticism of Nigerian scholars may be directed at the early feminism, when there was no attention to differences in ethnicity, colour and class between women. Within contemporary feminist theory, gender relations have 'to be understood to be constituted within a cultural, economic and political system that is also historically situated. Such systems involve race, ethnicity,

class and other forms of inequality that must be integrally incorporated into any gender analysis' (Lamphere et al. 1997:4). When analysing the influence of gender relations on abortion experiences of women, I am conscious of the differences within the female gender: between single and married women, educated and not educated, rural and urban, with and without children, young and old.

My professional position was that I started from the empirical, with gender as an analytical category, not from the theoretical, with gender as a political category. The subjective reality of gender relations for women and for men will be an outcome of the dynamics of dominant rules for gender relations, material and practical conditions and individual agency. This implies that researchers should explore the dynamics between dominant societal rules on (ideal) gender relations, the practices of relations as can be observed *and* the subjective reality and meaning of these practices. In terms of this study, it would mean, for example, exploring how women experience their abortion decisions in terms of their gender role in society.

My concern in this book is not to disprove or confirm Yoruba women's gender subordination, but rather to determine how the dominant rules for gender relations and the subjective reality of their gender position influence women's choice for fertility regulation practices, including that of abortion. A pertinent question in this respect is whether gender relations 'allow' women to be in control of their choices or not. Pearce (1995:198) observed that by paying bridewealth, Yoruba husbands and in-laws buy control over their wives' sexual and reproductive functions, and that women thus have very little control over their fertility, and by extension, fertility regulation. This, according to Pearce, was the case in the past, and remains so nowadays. The patrilineage has a vested interest in high fertility in order to perpetuate the lineage; most wives have the same interest, because their social standing is dependent on their production of (many) children. In a study of gender in sub-Saharan Africa, Baerends (1994:30) is less definite about the absolute control of the husband and his family, but suggests that in patrilineal societies, the in-laws have a strong interest in a wife's decisions and the wife's and her in-laws' interests may be in conflict. Thus, the dominant rules of patrilineal society would constrain or at least condition women in the control of their fertility. Gender relations may also instigate practices of specific fertility regulation methods. For example, use of male-controlled methods of contraception (condom or withdrawal) may be more in consonance with the prevailing ideal gender roles. However, other contextual and personal factors may cause women to disobey the societal dominant rules about appropriate gender behaviour when this behaviour does not serve their personal interests.

Coping

Various sections in this book describe how women are confronted with stressful situations: when they are faced with unwanted pregnancies, experience complications of induced abortion and fear or actually suffer from problems with fertility. Individuals may cope with these stressful situations with practices and behaviour that would be considered dissident in normal situations. Theories of coping, originating from the field of psychology, describe the strategies that individuals may use to deal with stressful situations. Coping has been defined as 'the process through which a person manages internal or external demands that are appraised as taxing or exceeding the available resources' (Lazarus & Folkman in Taylor 1986, quoted by Meursing 1997:43).²¹ Coping consists of behavioural and inter-psychic efforts to manage, i.e. to master, minimise, or tolerate, stressors and demands that may be internal (such as physical pain) or external (such as living with a violent spouse).

The first step in coping with a stressor is to make a primary appraisal of whether, and in which ways, the event poses a threat to the individual. In this study, for example, it means that a woman with an unplanned pregnancy appraises whether and why the pregnancy is unwanted, and what the threats are to her and possibly her partner or others involved. After having judged the event as threatening, the individual makes a second appraisal of what resources and potential coping strategies are presently available to deal with the stressor (Folkman & Lazarus 1991, cited by Meursing 1997:44). A woman faced with an unwanted pregnancy may think of aborting or keeping the pregnancy, and appraise the material and personal resources she has at hand.

The second appraisal of available resources is the most important in determining the style in which the person approaches the stressor and in the choice of further strategies. She may try to deal with the stressor itself, which is *problem-focused* or *active* behavioural coping, or turn to *emotion-focused* coping, which is dealing with the emotional strain the stressor invokes. Persons usually resort to emotion-focused coping when they feel they have little or no control over the stressor, and to problem-solving coping when they believe they can organise and execute the courses of action required to deal with the stressful events.

Avoidance coping is a frequently used form of emotion-focused coping, defined as 'strategies that focus attention away from the stressor itself or one's psychological/somatic reactions to the stressor' (Meursing 1997:46). Some types of avoidance coping may be psychologically beneficial to the individual. This can be the case when the stressor is of short duration (not thinking about a painful procedure while undergoing it). However, when dealing with a severe stressor, the actual impact of avoidance coping on the stressor itself must be considered.

Stressors which may be harmful to the individual or to others, like HIV, cancer or complications of abortion, need active, problem-focused coping in order to limit as much as possible the chance that serious harm will occur to the individual under stress or persons in her/his environment.

The choice of coping style (problem-focused or emotion-focused) is influenced by many factors, including the problem at hand and personal and contextual variables. In practice, many stressors evoke coping strategies of both kinds, but generally one style or the other is dominant. Meursing (1997:53) pointed to the fact that very few studies paid attention to the influence of material resources on the choice of coping strategy. The few studies that did find that access to practical and material resources, such as money and appropriate services, are of prime importance for coping with a stressor, both in a practical and psychological sense. Access to adequate material resources is associated with more problem-oriented coping and a heightened sense of control or self-efficacy. In addition to material resources, the availability of social support plays an important role because it may increase the instrumental means to deal with a problem, practically, materially and emotionally. Obtaining social support is an interactive process. Through a problem-solving style of coping, individuals may seek social support and thus receive more support, and in that way are able to obtain enough resources to solve the problem. On the other hand, individuals who tend to resort to emotion-focused coping may not seek social support, and therefore do not get it, and are then not able to solve the problem and feel out of control. Social role models further influence a person's self-efficacy beliefs. If a person has seen or has heard about others who succeed in coping with a similar problem in a certain way, her/his belief in self-efficacy will grow. The example of (believed) successful social models might transmit knowledge, skills and strategies to achieve desired ends.

Task models of coping specify the multiple aspects of a problem situation. The individual involved will perceive a hierarchy of tasks to cope with the stressors, especially in a crisis situation. Some urgent aspects of the problem will have to be dealt with first, while other aspects can be coped with later. Most of the stressors related to unwanted pregnancy and to abortion will be of such a crisis situation and the perceived priority of aspects of the problem will influence the coping strategy and, by extension, the coping outcome.

Some ways of coping that persons use will be successful, whereas others will not be. Taylor (1995:293) summarises, 'Coping efforts are judged to be successful when they reduce physiological indicators of arousal, enable the person to return to pre-stress activities and free the individual from psychological distress'. Thus in coping theory, successfulness is measured for the individual involved, and not for the effects individuals' coping have on other persons involved or society at

large. Some of the ways of coping with the stressor of unwanted pregnancy, as explained in this book, were extremely unsuccessful – they resulted in social repercussions, lifelong health problems or death.

Agency, tactics and strategy

Coping, no matter which style is used, is how an individual deals with a stressful situation. All coping could thus be considered as 'agency' which is a concept frequently used in sociology and anthropology. It is broadly defined as 'an individual making active choices' (Gammeltoft 1999:6). Lopez (1997:160) discusses the 'ideology of choice', which is based on the assumption that individuals have options and are free to choose from infinite alternatives. She points out that choice (and thus agency) is always conditioned by the sociocultural, economic and political context, and is more or less constrained by fragmented knowledge and (un)available services and technology. Lopez (1997:161), who studied sterilisation by Puerto Rican women in New York City, concluded that health-care policy and the availability of devices, ideology, service provision and subsidisation played important roles in narrowing women's fertility choices.²²

Agency means that people make decisions within the limits of their constraints (Lopez 1997:157). 'Free' agency, in which individuals choose for action to pursue their interest without constraint is a utopia; it does not exist. Likewise 'non'-agency or complete passivity is the non-existent other extreme of the continuum that ranges from non-agency to 'free' agency. Individuals always exercise some active choice, even if they seem to passively follow the societal rules. Paradoxically, compliance may be an active strategic choice (Moore 1988:180). This was already implied by Pearce's discussion, presented before, of Yoruba women's personal interest in complying with the rule of post-menopausal sexual abstinence (Pearce 1995:204). It shows the importance of empirical work in which respondents explain their motivations, paying attention to the positive reasons why individuals comply with majority rules.²³

Concerning the association of choice and constraint with decision making, Carter (1995:62) distinguishes two types. The first is 'programmed decision making' in which individuals decide on courses of action in advance of undertaking them; the second is 'habitual behaviour' in which people follow routines or conventional rules. For abortion-related decision making, further discrimination of types of active decision making ('programmed decision making') by Ortiz is useful (cited by Carter 1995:62). Ortiz differentiates between 'planning decisions' which are made well in advance of the activity with which they are concerned and 'on-the-spot-decisions' which are made just before action is taken. With 'planning decisions', agents have information and know what they

are trying to achieve, while 'on-the-spot decisions' are made in the flow of actions, and actors may be less informed and may have less idea of the outcome they would like to achieve.

Agency usually has connotations of resistance and change, although as discussed earlier, compliance may be a type of agency. By aborting, women theoretically resist dominant societal rules (assuming that the rules are against abortion). The important question becomes whether women *experience* their practices as 'resistance'. This is a methodological and ethical question aptly described by Gammeltoft (1999:245) in her study of IUCD use by women in rural Vietnam. She asked herself whether 'an understanding of suffering [physical suffering from the side-effects of IUCD] as resistance represents a social-scientific appropriation of women's bodies and lives which turns them into something very different from what they are as experienced'. The scientist's interpretation of motivations and intentions may differ widely from the lived experience of the individuals under study. According to Good (1994:61), this is a general objection to the work of many critical medical anthropologists, who look for the causes of health problems in the macro-level political, economic and social context. These scholars often privilege their perspective over that of the persons they study who are believed not to have the knowledge and understanding of what *really* is the cause of their suffering and their experience. Resistance might thus be an analytical tool and not something experienced by the persons whom the anthropologist studies.

I believe that when an anthropologist is committed to applied research that is intended to provide recommendations how to solve a health problem, (s)he has to strike a balance: To provide a critical analysis and interpretation of problems by looking for causes and solutions at all possible levels and from all possible angles, but based on empirical research of the practices and lived experiences of individuals affected by the problems.

In this book, I stick to the term 'agency' to refer to the active choices of individual women, but I am careful not to call agency that opposes dominant rules 'resistance' because resistance implies the actor's consciousness and intention. I will also be careful with the word 'strategy', a term normally used in coping theories and discussion of women's agency. 'Strategy implies the ability to organise consciously and suggests a clear-sighted (collective) vision that supports an optimistic dream for the future' (Nencel 2001:215, quoting Scheper-Hughes 1992). Scheper-Hughes makes a distinction between 'strategy' and 'tactics' and, according to her, 'tactics' is a more appropriate characteristic of individuals living in poverty. 'Tactics are often defensive and individual, not aggressive and collective practices (...) they do not challenge the definition of the political-economic situation' (Scheper-Hughes 1992:471-472 cited in Nencel 2001:215).

Gammeltoft (1999:246) also thought the concept of 'tactics' was more appropriate for describing the actions of the women in her study than 'strategy' was. Similarly to Scheper-Hughes, she states that strategy implies consciousness and that the actor aims to get what (s)he wants, whereas pragmatic, everyday tactics is manoeuvring within social fields of demand and constraint. Lopez (1997:167) discusses social space: when social space is small, agency may take the form of tactics, whereas when individuals have a wide social space in which to function, their agency may be more of a strategy. Thus, the difference between tactics and strategy is a matter of definition and gradation: individuals apply tactics when their agency is more constrained and strategy when agency is more free and conscious. In this book, I will explore whether abortion in Yoruba society can be considered as a female group strategy against dominant rules, or rather as the tactics of individual women who are manoeuvring within their constrained social spaces.

Content of chapters

In the next chapter I will describe the study methodology. One of the premises of the study was that a public health problem such as abortion needed an applied participatory study. The chapter explains the gradual development of the study methodology that used triangulation of both quantitative and qualitative data collection techniques and involved a variety of study populations and locations in urban and rural areas of Lagos State.

Chapter 3 pays due attention to the rich culture of Yoruba society, with emphasis on aspects in their culture relevant to the discourse of this book. This chapter situates the Yoruba culture in the national context of economic austerity and competition in education. By the combination of literature, information from respondents and my observations, I try to differentiate between the rules and reality of Yoruba society.

Chapter 4 juxtaposes the prevalence of abortion with the societal rules about abortion. Public opinion condemns termination of unwanted pregnancies for most reasons. However, this opinion does not prevent abortion being very common, especially among single girls and women. Figures show that some groups of women are at a higher risk of suffering complications from induced abortion, including death, because they resort to unsafe abortions more often than others do.

Because strategies for coping with unwanted pregnancy and abortion practices differ greatly for married and single women, they are discussed in separate chapters. Chapter 5 describes personal abortion experiences of single girls and

women, and shows the differences in motivations and practices between sub-groups: those in any form of schooling and those not schooling. Chapter 6 presents the abortion experiences of married women and describes why they might resort to abortion. Abortions by married women occur relatively less frequently, but still happen, even though Yoruba society is pronatalist and dominant rules dictate that all children conceived in marriage are wanted.

One of the central questions of this book, why so many women do not use contraceptives that would prevent them having to resort to abortion, is dealt with in Chapter 7. The various sociocultural and service-related factors influencing non-use are discussed. Chapter 8 then arrives at the Yoruba preoccupation with fertility. Infertility is a stigma, especially for women. Because of the fear of infertility, women make decisions that may be detrimental to the very reproductive health they are trying to protect. These decisions dictated by fear may actually cause their anxieties to become reality, when women develop secondary infertility due to their abortion of an unwanted pregnancy.

In Chapter 9, I discuss the study findings in the context of Yoruba society, literature on abortion and contraception and theoretical concepts. The chapter concludes by making recommendations for solutions to the many problems associated with abortion, inspired by suggestions produced in participatory sessions with students, women, men, traditional birth attendants and biomedical service providers.

