Secret strategies: Women and abortion in Yoruba society, Nigeria
Koster, W.

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CHAPTER 2

STUDY METHODOLOGY

The fieldwork for this study was carried out over a period of about three years, from 1996 to 1999. The two main study locations were Lagos metropolis, the former federal capital, and Epe, a rural LGA (Local Government Area), both within Lagos State in Southwest Nigeria. I believe the fieldwork and the way the study methodology developed in three distinct phases deserves an extensive explanation in a separate chapter, for several reasons. Firstly, studying sensitive intimate topics such as abortion, and in particular induced abortion, need special research methodologies. Secondly, some of the research methods could be useful for other studies. Finally, it will make the book more 'reader-friendly', because it will prevent confusion, when I refer to the many different study methods, locations and populations involved.

Let me explain at this point that when I speak of 'abortion' in this book, I mean induced abortion. Additionally when I talk about 'women', I refer to females of all ages and social backgrounds. Where applicable, I will qualify the term 'women', for example by referring to their age group, marital status or schooling status.

Premises

I started fieldwork with a very flexible theoretical and methodological framework, guided by the premises elaborated below.

Applied research

My conviction is that research on a serious public health problem like abortion should be applied; it should aim at contributing to finding solutions to the problem. I did not want to study a topic of this nature for academic purposes only. Moreover, applied research would possibly facilitate the collection of reliable data. I assumed respondents would weigh what they have to lose against what they stand to gain from giving true information. If they acknowledge that
their co-operation is in their own interest, or that of their children, they may be more inclined to give true information (see also Ehrenfeld 1999:371).

Participatory research methodologies are needed to get all stakeholders — women, men, youth, health-service providers and policy makers — involved in identifying and analysing the problems and finding solutions to them. However, such a conviction also poses problems for the research: How involved could I be, how objective should I be, what was my position? According to Maguire (1987), a feminist American scholar who worked with battered women in New Mexico, participatory research is necessarily subjective. To summarise her argument:

Participatory research does away with the ideal of dominant positivist research, that research should be objective, that it should not influence the social environment of people studied, that there is such a thing as objective reality to be studied. Objectivity requires the researcher to be detached from the researched. Alternative participatory research aims to develop critical consciousness to improve the lives of those involved in the research process and to transform fundamental societal structures and relationships. Both the research process and the outcomes should help them: to give them a voice in articulating their perception of the problem and relevant solutions (Maguire 1987:1-8).

I think a researcher should not carry too many assumptions into the study. Maguire, for instance, talks throughout her book about ‘self determination’, ‘women’s emancipation’, and ‘social transformation’ as inherently desirable things to be achieved by the women she worked with. In this context, I would like to refer back to the critique by some Nigerian female scholars that I mentioned in the literature review of gender perspective. They believe that some Euro-American feminists studying gender in Africa bring too many Western values and concepts into their studies (Amadiume 1987; Oyewumi 1997; Pearce 1995). I wanted to be careful about airing my convictions. I had liberal views on abortion, coming from the Netherlands where abortion is legal and free, and where there is little, if any, stigma attached to having one. The Dutch law allows both single and married women to decide for themselves to abort. I did not want to ‘preach’ or ‘aim’ for this situation as preferable for Yoruba. The subjective aspect of the present study is that the topics of discussion and research were partly my choice and might not have been the participants’ priority problems. (They would most likely have chosen economic problems as priority). Although the present research was not purely participatory because it did not involve shared power to define the agenda, objectives and methods of research, it was participatory because it was dialogical, involved exchange of knowledge, and focused on change, i.e. decreasing the problems related to abortion (see also Tan & Hardon 1998:3-8).
I trusted that my dual status of insider and outsider would be beneficial to the study rather than a problem. I was raised and trained in the academic traditions of Western Europe, and I have white skin. These facts make me an outsider. However, because I was married to a Yoruba, carried his name, and had children ‘for him’ who have Yoruba names, Yoruba considered me as one of ‘their wives’. Having lived among my study population for seven years as a member of a Yoruba family made me familiar with the society. Yet, conducting the study and reflecting on the findings have given me far greater insight.

**Abortion in context**

In an applied study, abortion cannot be studied in isolation, but has to be regarded in light of other fertility regulation practices including contraception and infertility treatment, which possibly influence abortion practices. Additionally, to be able to determine the influence of structure on individual abortion practices, abortion should be situated in the socio-economic and cultural context at different levels: the micro-, meso- and macro-levels. The study therefore required a multilevel framework of data collection and analysis from the perspectives of individual women, communities, service providers and national policy. I theorised some mutually related socio-economic, cultural and services-related factors that possibly influence women’s decision to abort and their abortion practices (Table 2.1)

<table>
<thead>
<tr>
<th>Table 2.1. Conceptual Framework: Factors influencing women’s abortion practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>possible factors influencing abortion practices</strong></td>
</tr>
<tr>
<td><strong>Women’s personal characteristics</strong></td>
</tr>
<tr>
<td>- socio-economic status, e.g. age, marital status, schooling, profession, level of formal education, religion</td>
</tr>
<tr>
<td>- aspirations for the future</td>
</tr>
<tr>
<td>- reproductive background: parity, children alive and dead</td>
</tr>
<tr>
<td>- experiences with fertility regulation practices and services</td>
</tr>
<tr>
<td>- type of conjugal/sexual relationship</td>
</tr>
<tr>
<td>- socio-economic position of boyfriend or husband in society</td>
</tr>
<tr>
<td><strong>Societal rules and norms related to:</strong></td>
</tr>
<tr>
<td>- sexuality</td>
</tr>
<tr>
<td>- conception, pregnancy and infertility</td>
</tr>
<tr>
<td>- fertility regulation: methods and side-effects</td>
</tr>
<tr>
<td>- gender ideology and decision-making between partners</td>
</tr>
<tr>
<td>- influence of extended family</td>
</tr>
<tr>
<td>- value of children</td>
</tr>
<tr>
<td><strong>Services and policy</strong></td>
</tr>
<tr>
<td>- availability, accessibility and acceptability of fertility regulation services</td>
</tr>
<tr>
<td>- laws and regulations (on abortion, access to contraception)</td>
</tr>
<tr>
<td>- population policy</td>
</tr>
<tr>
<td><strong>Economy</strong></td>
</tr>
<tr>
<td>- micro- and macro-level economic situation</td>
</tr>
</tbody>
</table>
Definitions and terminology

The present study was focused more on the intentions and motivations of why women use certain methods of fertility regulation than on the exact procedures and their biomedical, scientifically-proven effectiveness. In this study, ‘fertility regulation’ comprises all methods and measures women and men use intentionally to influence their natural fertility. These are methods intended to prevent pregnancy (pre- and post-coital contraception), promote conception (infertility treatment) and terminate a pregnancy (induced abortion), whether they can be proven to be effective in clinical trials, or not. In practice, this means, for example, that when a woman reported she had successfully aborted a one month-old pregnancy by taking some drugs, this was counted as an abortion, even though it might have been a spontaneous miscarriage totally unrelated to the drugs purportedly used to abort. The study definition of induced abortion is thus ‘all pregnancies that were reported by the respondents to have been aborted’.

The reasons for this focus were both theoretical and practical. Theoretically, the fact that women try to regulate their fertility, though ineffective or with an unintended result, demonstrates their agency. Practically, in view of promotion of effective and safe fertility regulation methods, the approaches regarding non-users or users of ineffective or unsafe methods would be different. In other words, motivating women to change their present ineffective and unsafe fertility regulation practices to effective ones would take different forms and probably require less conviction than making non-users of fertility regulation accept them. I assumed that women and men who try to regulate their fertility would benefit from using safe and effective fertility regulation methods.

To prevent biased responses to the wording of questions in interviews, I used broad definitions and paraphrases. Respondents might misunderstand biomedical concepts such as ‘family planning’, ‘infertile’, ‘abortion’ and ‘contraception’. For example, a girl might respond she does not use ‘family planning’ because she thinks the question inquires whether or not she uses pills or condoms. However, she may regularly try to prevent pregnancy by ‘watching her safe period’ or by taking antibiotic pills after intercourse. As discussed above, in the present study, these would be counted as contraception. Therefore, in interview questions, potentially ambiguous terminology was paraphrased. For instance, instead of asking women whether they used ‘family planning’ (or ‘contraception’), I asked women whether they took any substances or did anything to prevent pregnancy when they did not want to be pregnant, either before or after intercourse.
**Data collection methodology**

An applied study should use methodological triangulation in which qualitative and quantitative data collection complement one another to both arrive at reliable and valid interpretations of data and get applicable results (see also Razum & Gerhardus 1999:243; Varkevisser 1998:90). Qualitative information can lead to a clearer understanding of the complex factors influencing decision-making, for example about whether to abort and how to do so. Quantitative data can indicate the magnitude and social or geographical distribution of an issue, and the strength of potential factors influencing the problem (Varkevisser 1998:75).

Because I wanted to understand the different fertility regulation practices and individuals’ motivations to use them, it was of first priority to use qualitative methodology. However, qualitative research on its own could easily lead to singling out the extraordinary (both negative and positive), which is usually more compelling than the ordinary. Because I wanted to concentrate on common practices and beliefs, surveys were necessary to complement the qualitative data collection. Whether we like it or not, ‘hard’ (quantitative) data rather than ‘soft’ (qualitative) data are more likely to convince policy makers of the significance of a problem and initiate a public discussion on the issues (Coeytaux 1988:188).

In this study I let qualitatively derived data inform the design of quantitative surveys. I would subsequently discuss the information derived from the surveys with stakeholders for validation and further interpretation. Because abortion was believed to be such a sensitive topic, the methods and tools to collect quantitative data could only be developed gradually, after I had explored the perceptions and willingness of women to talk about it. This hesitancy to rely on surveys, or blind faith in surveys comes from experiences like that of Bleek. Bleek, who did his study of birth control among the Akan of Ghana, found that surveys did not give reliable answers on delicate issues and that in-depth interviews in an anthropological research setting can produce answers closer to reality.¹

That an informant’s unwillingness to co-operate increases, as the topic becomes more intimate and embarrassing, goes without saying (...). Interviewers who ask personal questions about delicate topics, sometimes with more sense of duty than common sense, force polite informants into lying ones (Bleek 1987:314).

Bleek is not the only researcher who had difficulty obtaining dependable data about reproductive practices. Several researchers have warned that it is difficult, and some even say impossible, to get reliable information on abortion from community surveys in countries like Nigeria where abortion is illegal (Baretto
et al. 1992:159-170; Coeytaux 1988:188; Figà-Talamanca 1989:12; Henshaw et al. 1998:157; Huntington et al. 1993:120). Respondents in community surveys do not want to disclose that they have personally violated common morals and trespassed national laws (by having an abortion) or that one of their family members did. As a result, these researchers have claimed, there will always be intentional underreporting.

The sensitivity of a topic such as abortion influences not only the method of data collection, but also the selection of informants. Many researchers did not even try to study abortion in the community, but got their informants among women who came to the hospital with complications of abortion (Mpangile et al. 1999:388-389; Okonofua et al. 1992). The problem with this is that these women do not represent all women who had abortions in the community, nor all women with abortion complications. To get a picture close to reality, I intended to study abortion also in a community survey, as well as in a hospital setting. I hoped that with sensitive data collection instruments and competent interviewers who could talk about abortion realistically, women would share their experiences of abortion and other intimate issues, such as contraceptive use and experiences with infertility.

Exploratory research

Three main, partly overlapping phases, each with its specific data collection methods, can be distinguished in the fieldwork: the exploratory phase, the survey, and the participatory phase. The exploratory phase took place from October 1996 to July 1998. My main aim in this phase was to determine the scope and range of key issues related to fertility regulation, and to become familiar with the sociocultural and health-service context at various levels. Moreover, in this phase I had to clarify how to get reliable data in a more extensive survey. Study methods were mainly in-depth, open interviews, natural informal conversations and observations carried out by myself. If needed, I was accompanied by Biodun, my Yoruba research assistant. Besides in-depth interviews, we conducted some short exploratory interviews and a trial of semi-structured interviews. The semi-structured interviews used questionnaires with mostly open and some pre-coded questions. I contacted the women, biomedical and ethnomedical service providers and their clients for interviews through networking (see Box 2.1). By ‘biomedical service providers’ sometimes shortened to ‘biomedical providers’, I mean doctors, midwives, nurses, and other medical personnel trained in biomedicine. Ethnomedical (service) providers are those healers trained in the practices of traditional Yoruba medicine, both
natural and spiritual. In Chapter 3, I pay due attention to the different type of Yoruba traditional healers.

The interviews with biomedical and ethnomedical providers and their clients were concentrated on Lagos Island, the heart of Lagos metropolis (see Box 2.2), because that is where my networking brought me. Other clients and the women who provided information via in-depth interviews came from all over Lagos metropolis. I conducted some in-depth interviews in my house and others in the interviewees’ homes. Table 2.2 gives an overview of the different groups of interviewees in the exploratory phase.

Table 2.2. Interviews in the exploratory phase (October 1996-June 1998)

<table>
<thead>
<tr>
<th>data collection method and study population</th>
<th>number</th>
<th>specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-depth open interviews with women</td>
<td>7</td>
<td>Number of interviews per woman ranged from 1 to 10; interviews were on all aspects of fertility regulation and Yoruba culture</td>
</tr>
<tr>
<td>Short open interviews with women who had infertility problems</td>
<td>29</td>
<td>27 in clinics of traditional birth attendants, 2 in community</td>
</tr>
<tr>
<td>Short open interviews with women</td>
<td>51</td>
<td>The research assistant conducted interviews with traditional birth attendants’ clients and in the community, on fertility regulation practices and perception of service providers</td>
</tr>
<tr>
<td>Short open interviews or natural informal conversations with biomedical providers</td>
<td>8</td>
<td>Doctors, matrons and midwives of Lagos Island Maternity Hospital were interviewed, mostly in multiple sessions</td>
</tr>
<tr>
<td>In-depth open interviews with ethnomedical providers</td>
<td>6</td>
<td>Multiple interviews with three traditional birth attendants in Lagos Island in their clinics, with one babalawo (Ifa priest), one elewe ona (herb seller) and one woli (priest of Aladura church)</td>
</tr>
<tr>
<td>Semi-structured interviews with antenatal clients of traditional birth attendants</td>
<td>66</td>
<td>Trial of interview setting</td>
</tr>
</tbody>
</table>

In addition to the interviews, the observations were an important source of information in this exploratory phase. Of course, the actual topic of research, fertility regulation practices and in particular abortion, could not be observed. However, I did observe the context in which these practices take place.
(1998:48) aptly stated: ‘Only by knowing the context do we begin to understand something about the events’. Being a member of a Yoruba family and living in a Yoruba neighbourhood made participant observation a way of life. However, I also went out to observe. I sat for hours and days in clinics of biomedical and ethnomedical providers to observe the clinic routine. Additionally, I visited informants at their houses. While going there, often on foot, I had the opportunity to see the living environment in Lagos. Only through observation over a longer period can a researcher sense the culture of a place, and differentiate between what is daily routine and what is extraordinary; in other words, what is normal in the setting and what is exceptional. Through observation, one gets a sense of the structure of the relationships between different staff members and between providers and their clients.

In the course of observation, I was able to have my questions answered by staff, clients and even just passers-by. I introduced myself as a researcher who

Box 2.1. Networking

How to start research? How to ‘enter’ into the community, how to find informants for interviews? For me it was relatively easy, after some initial shyness about ‘bothering’ people with my questions on topics that they might rather not discuss. Being married to a Yoruba with a well-known name was extremely helpful in opening many doors. Because I was an in-law of the *oba* (king) of Lagos, I got the initial co-operation of traditional birth attendants (TBAs). The *oba* is held in high esteem by traditional healers, since he is also endowed with much spiritual power. (I like to believe that later, the rapport with the TBAs was also due to their genuine interest in the project activities of this study).

My in-laws were often the first connection to wider networks of participants for the study. At my sister-in-law’s house, I met a medical doctor working in the Lagos Island Maternity Hospital who assisted me in getting official permission to interview clients and staff. It was also through my in-laws that I got in touch with someone to teach me Yoruba, Bola. Bola was a secondary school teacher in Yoruba language and culture. Besides being my language teacher, she was an important informant and stayed involved in later stages of the research: as an advisor on Yoruba culture and as facilitator in seminars with TBAs. Through her I was able to start an education project in the secondary school in Lagos, where she worked.

Biodun, a 26-year-old married mother of two, was my second informant in the exploratory interviews. I initially met her as the wife of my husband’s mechanic. After having interviewed her several times, she proved to be very interested in the study, resourceful and ambitious. At her own initiative she introduced me to Baba Rashidi, the TBA with whom she delivered, and proved to be a good interpreter, having finished secondary school. Baba Rashidi then introduced me to other TBAs. After some months I involved Biodun in the study as a full-time research assistant. She conducted interviews independently, interpreted, organised meetings and in later stages of the research, helped me to enter qualitative information on compilation sheets.
wished to learn about Yoruba customs and practices and especially those related to childbearing and fertility regulation. Depending on the person I was talking to I adjusted the detail, wording and emphasis of my introduction. Some of my observations are presented in the ‘boxes’ throughout this book.

The exploratory phase revealed that women and service providers had been surprisingly open in talking about the allegedly sensitive issues such as abortion, contraception and infertility problems during in-depth interviews. Based on these findings, I was convinced that given a conducive environment, women in the community would also be willing to share their experiences of abortion and other fertility regulation practices in a survey setting. I had started the fieldwork without funding, so it was opportune that during the exploratory phase, the Ford Foundation gave me a project grant. I now had the finances to work full-time on the study, hire assistants, conduct large-scale surveys, hold seminars and workshops and make it altogether a bigger study than it could have been otherwise.

**Surveys**

The survey phase ran from September 1998 to February 1999. The aim of this phase was to get an indication of the magnitude of issues, the social distribution of the findings of the exploratory phase and the strength of the influencing factors. I also wanted to broaden the location of research to include other areas of the Lagos metropolis (beyond that of Lagos Island), as well as rural areas of Lagos State. The target sample size I had set was rather large for an anthropological study, but I felt it important to have a large sample size because I wanted to get enough abortion experiences to be able to make some inferences on associations, for example between subgroups of women and unsafe abortion. I aimed for 1,000 abortion experiences. A total of 1,447 women and 39 traditional birth attendants were interviewed in the survey phase.

**Sampling**

I selected study locations and populations through a combination of purposive and convenience sampling, and not by random sampling. I wanted to concentrate on the poorer parts of society because I expected the problems to be bigger there. Wealthy women can afford to obtain safe abortions in private hospitals of high standard. Therefore, the sample of the five study locations in Lagos metropolis was purposely biased towards low-income areas. Moreover, the locations had to be relatively easily accessible, safe to work in and with a majority of Yoruba residents. Rural areas in Yoruba land are usually low-income, so any
rural LGA in Lagos State would have been suitable for meeting that requirement. In some rural LGAs of Lagos State there has been an influx of other ethnic groups. This influx means fewer Yoruba, and additionally, ethnic unrest frequently flares up which makes fieldwork more hazardous and can interfere with scheduled data collection activities.

Epe Local Government Area (LGA) was selected to represent the rural area, because it is a relatively peaceful rural LGA inhabited mostly by Yoruba. Epe town, the LGA headquarter, is about a one-hour drive from the outskirts of Lagos metropolis on a good tarmac road. The four study villages in Epe LGA were up to one-and-a-half hours from Epe town over secondary roads, some of bad quality. We selected villages in each of the four LGA districts; they had to be accessible by car and foot and be inhabited mainly by Yoruba.8

Box 2.2. Study locations

The differences in living conditions between Lagos town and Epe are extreme; they seem to be different worlds. Yet, geographically the distance is not far, only about 80 kilometres.

Isale Eko, the heart of Lagos Island, is a maze of narrow streets bordered by old and often dilapidated multi-storey houses that harbour small shops and workshops at the ground floor. On the sidewalks, if there are any, or on the edges of the streets, the shops display their merchandise. Small traders sell their wares and women sell cooked food in makeshift restaurants that are constituted of a small wooden table and a bench. An unending flow of women, men and children navigate in between cars, push-carts with merchandise and male and female porters with incredible loads on their heads. There is a lot of loud music, from eating places, shops, and from boys walking around with ‘ghetto blasters’ – the radio station of choice is 92.7 FM. In between these busy narrow streets there is yet another maze of alleys only accessible to pedestrians, bicycles, motorcycles and push-carts. Here, it feels like a village. A large part of life takes place outside the house. Women plait their hair in their house-clothes, children eat, women prepare food, dry pepper and sit and talk. When one peeps through gates along the alleys, one sees peaceful courtyards where people seem to live outside, amidst their chairs, beds, cooking stoves and utensils. It is in this type of setting that many traditional birth attendants have their clinics.

Going to relatively tranquil Epe from busy, crowded Lagos was always a relief to me. I enjoyed the drive over the quiet road bordered by bush and farm fields. Epe LGA headquarter is an old town, or rather a big village, located on an elevation at the waterfront of the lagoon. From several locations in Epe, one has a scenic view over the water and surrounding green. One feels the spaciousness here. Compared to Lagos, the streets are wide and the houses are not packed together. However, people may live crammed with many others in one big house, in which several families live. Going to the villages in Epe LGA was even more enjoyable, although travelling the roads with numerous potholes was sometimes an ordeal. Villagers mostly live from farming cassava and yam, and from fishing. The villages consist of small, scattered houses built of sun-dried bricks or mud, with roofs most commonly made of corrugated iron sheeting, or sometimes thatch. It can be deduced that many villagers are poor from the clothes adults and children wear, the state of the houses, the scanty furniture, the single bare light bulb and the cooking done on firewood. The friendliness and enthusiasm of the villagers, though, was heart-warming.
Study locations in Lagos metropolis
Study locations in Epe LGA
In Lagos and Epe I selected several health institutions at which I would interview service providers and their clients. In Lagos it had not been difficult to select a hospital, since there is one main public maternity hospital in the city centre, Lagos Island Maternity Hospital (LIMH), also called 'the baby factory'. The traditional birth attendants on Lagos Island, whom I interviewed in the exploratory phase, said that they would refer clients to this hospital because it was good and they had an established referral system, using special forms. It was opportune that LIMH received most of the more serious complications of induced abortion, including those from other areas than Lagos Island. Onikan Public Health Centre on Lagos Island, with a busy ANC clinic, was another location I selected for interviewing clients. Epe has no separate public maternity hospital, but the maternal and child health (MCH) services are part of the general hospital. The Lagos State Hospital Management Board (LSHMB) had given me permission to visit any unit and to interview both staff and clients within the hospitals and clinics.

During the exploratory phase I had discovered that traditional birth attendants, or *gbonogbe* (literally: owners of small children) are the key informants for ethnomedical knowledge and practices of fertility regulation. As such, in Lagos Island and Epe LGA, I contacted the association of traditional birth attendants. I selected TBA clinics for interviewing clients both through networking and on purpose. I had already been working in Baba Rashidi's clinic in the exploratory phase so I continued to work there during the survey phase. Additionally, I selected the clinic of the TBA Sikiru Lawal because he seemed to be more inclined to combine biomedicine with traditional medicine, which I thought, was interesting. The clinics at which we did surveys in Epe were of those TBAs who had asked us to do so. Their treatments ranged from those of mainly traditional medicine to an assimilation of biomedicine with traditional treatments.

**Table 2.3. Study locations for interviews with women in the survey phase in Lagos and Epe**

<table>
<thead>
<tr>
<th>study locations</th>
<th>Lagos town</th>
<th>Epe LGA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communities for</td>
<td>Lagos Island</td>
<td>Epe town: Aiyetoro and Papa</td>
</tr>
<tr>
<td>Community survey</td>
<td>Surulere</td>
<td>Igbonla</td>
</tr>
<tr>
<td></td>
<td>Mushin</td>
<td>Museju &amp; Mutaku &amp; Egon</td>
</tr>
<tr>
<td></td>
<td>Orile</td>
<td>Ikosi</td>
</tr>
<tr>
<td></td>
<td>Ebute Metta</td>
<td>Ajebo &amp; Orugbo</td>
</tr>
<tr>
<td>Health institutions for interviews with clients</td>
<td>Lagos Island Maternity Hospital</td>
<td>Public general hospital (Epe town)</td>
</tr>
<tr>
<td></td>
<td>Onikan Health Centre (Lagos Island)</td>
<td>TBA clinic Baba Pupa (Epe town)</td>
</tr>
<tr>
<td></td>
<td>TBA clinic Baba Rashidi (Lagos Island)</td>
<td>TBA clinic Suleiman Junaid (Epe town)</td>
</tr>
<tr>
<td></td>
<td>TBA clinic Sikiru Lawal (Lagos Island)</td>
<td>TBA clinic Mrs. Olufisayo Ige</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Agbowa District)</td>
</tr>
</tbody>
</table>
We interviewed all women present in the selected health institutions at the time of interviews, after asking permission – there was hardly a refusal. For selecting women in the communities, there was no sampling frame, but I gave some instructions to interviewers. Women were interviewed who just happened to be around, either on the street or in their houses. In the villages of Epe nearly all women were interviewed, because the inhabitants are so few. At one location we even had to go to a nearby village (Egon) because we could not reach the sample target. In areas where there was an abundance of women, I gave instructions to interviewers to approach women of different ages and socio-economic strata. There were only a few women who did not want to participate.

The selection of TBAs for interviews was based on their willingness to volunteer. I introduced the study to TBAs in Lagos and Epe in their respective associations meetings. We visited and interviewed all TBAs who had indicated they wanted to be involved in the study: 22 out of 30 TBAs in Epe and 17 out of 25 in Lagos.

Data collection tools and samples size

Several semi-structured questionnaires that contained mainly open and some pre-coded questions were used to interview women. Some of the instruments were developed in stages, with some questions added in later interviews. This is the main reason that total figures in tables may vary; questions that were developed later were not put to all women who were interviewed. The surveys with women started in antenatal and gynaecology (‘gynaec’) clinics of ethnomedical and biomedical institutions, and then expanded to the communities. We used three different semi-structured questionnaires, which I will refer to as the ‘ANC survey’ (clients interviewed in ANC clinics), ‘infertility survey’ (clients in gynaec clinics) and ‘community survey’ (women interviewed in the community). Many questions were similar in the three questionnaires, such as those about ever-use of contraceptives and reproductive history, but there were some specific questions asked to infertility clients and ANC clients on their current experiences with infertility treatments and pregnancy, respectively. Additional separate questionnaires were administered to those women in the three surveys who had experiences or information to share concerning abortion. These additional questionnaires were on ‘unwanted pregnancy not aborted’, ‘abortion’ and ‘death from abortion’.

The ‘abortion’ questionnaire was also administered to community women and clients in public health institutions and TBA clinics in Lagos who were not respondents in the other surveys of the present study. I did this because I realised I needed more abortion experiences to be able to perform statistical tests,
and I was short of the 1,000 experiences I had set as a sample target. By networking in the community and from patient files in health institutions, we identified women who had had an abortion (indicated as TOP, termination of pregnancy, in patient files) and interviewed them. These women specifically interviewed on their abortion experiences are not included in calculations of the prevalence of abortion. They constituted the additional 349 who answered the 'abortion questionnaire' and made the total of women reporting one or more abortions 652. Together, these 652 women had had 1073 abortions. At this point I would like to draw attention to the fact that the total number of respondents of the community survey is the same as the total number of women interviewed about abortion experiences, because the overlap in numbers might be confusing to the reader. This occurred purely through coincidence; they are not the same women, except for the 157 respondents of the community survey who had an abortion and thus answered the abortion questionnaire.

Of the women in the community survey, 106 had known a woman whose death had been caused by induced abortion and answered the 'death from abortion' questionnaire. Table 2.4 explains the study populations of women in the survey phase and the additional questionnaires that were administered to them; the table serves as a point of reference for the rest of the book.

Table 2.4. Number of women interviewed in the survey phase by study population and location, with number of additional questionnaires on specific topics administered to them

<table>
<thead>
<tr>
<th>study population</th>
<th>locations in Epe and Lagos</th>
<th>sample size</th>
<th>unwanted pregnancy not aborted</th>
<th>abortion</th>
<th>death from abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility clients (Infertility survey)</td>
<td>Clinics of TBAs and public health institutions</td>
<td>69 (Lagos: 36; Epe: 33)</td>
<td>2</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>ANC clients (ANC survey)</td>
<td>Clinics of TBAs and public health institutions</td>
<td>367 (Lagos: 179; Epe 188)</td>
<td>74</td>
<td>122</td>
<td></td>
</tr>
<tr>
<td>Community women (Community survey)</td>
<td>14 communities</td>
<td>652 (Lagos: 283; Epe 369)</td>
<td>103</td>
<td>157</td>
<td>106</td>
</tr>
<tr>
<td>Women who had abortions (not in one of the three surveys)</td>
<td>Communities, TBA clinics, public health institutions</td>
<td>349 (Lagos: 348; Epe: 1)</td>
<td>349</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1447</td>
<td>179</td>
<td>652</td>
<td>106</td>
</tr>
</tbody>
</table>
The socio-economic background of women in the public and TBA antenatal care clinics is reasonably representative of the married female population (only 6% of ANC clients were single). I base this conviction firstly on the fact that the vast majority of married women will get pregnant. The second reason is that this study found that most women use a combination of public, private and traditional services for ANC; only the rich, of whom there are very few, may uniquely attend the high-quality private institutions for ANC treatment. However, although representative for married women, the ANC survey was not useful to calculate prevalence of all variables I was interested in, because these would be atypical among ANC clients. For example, all ANC clients by definition are pregnant, most are married, and they do not presently have infertility problems, although they might have had problems sometime during their lives. We obviously could not ask them about current contraceptive use and present wish for pregnancy.

Gynae clients, on the other hand, were only married women with current infertility problems, and I did not consider them representative of the general married female population. I did not, for example, include them in the calculation of prevalence of ever-use of contraceptives, since women with infertility problems would mostly be non-users; I also did not include them in the calculation of the prevalence of abortion, although many of these women had had abortions.

The women interviewed in the community survey are representative of the general Yoruba female population. With the findings of this community survey I could therefore determine the distribution of all variables. The ANC survey could be used (in addition to the community survey) to calculate prevalence of ever-use of contraceptives, unwanted pregnancy and abortion (but not of for example current use of contraceptives and ever infertility problems).

In Appendix A, the profiles of the study populations of the three surveys can be found, including their age group, religion, educational level, present occupation and marital status. The ages of women in the three surveys ranged from 15 to 49, with slightly more Muslim women than Christian, about half who went up to secondary school, and about 60% being presently engaged in petty trading or crafts. In the community survey 72% of the women were married, 25% single and 3% widowed or divorced.

In addition to the women interviewed, 39 in-depth interviews were conducted with TBAs (22 in Epe and 17 Lagos), from September 1998 to February 1999. The question guide we used for these interviews was developed from the experiences of multiple interviews with the three TBAs in Lagos in the exploratory phase of the study.
Structure of data collection instruments

The way of sequencing the questions, the neutral way the questions were framed and the use of filter-questions established rapport between respondent and interviewer and facilitated reliable answers. In the surveys we asked questions on all fertility regulation practices, including contraception, infertility treatment and abortion. In the ANC survey we added questions about delivery care.

Questions on abortion were asked in two ways. Abortion came up relatively early in interviews when discussing the woman’s socio-economic, educational and reproductive background. We asked questions about the number of pregnancies, the number of children alive presently, the number of spontaneous miscarriages, stillbirths, ectopic pregnancies, children who died and the number of induced abortions she had had. The interviewer had to check whether the ‘pregnancy wastage’ and children who died tallied with the total number of pregnancies reported, but was instructed to not point it out when it did not add up correctly. Towards the end of each questionnaire, filter-questions were used to again introduce questions on abortion. First the woman was asked whether she ever had a pregnancy that she was not ready for at the time she found herself pregnant – this was counted as an unwanted pregnancy. If she had such an experience, she was asked in an open question what she did with this pregnancy. She may have continued the pregnancy and coped with the situation, tried in vain to abort it, or successfully terminated the pregnancy. If the woman had not reported in the beginning that she had an abortion, the interviewer adjusted the first question on abortion. We asked the interviewee an additional set of questions on each abortion experience (if she had more than one). Questions included her age, schooling and marital status at the time of the abortion, the reason for the pregnancy to be unwanted, method of abortion, month of pregnancy, whom she involved, complications and how she reacted to them and contraceptive use before and after abortion. (Appendix B presents some of the data collection tools developed for and used in the study.)

The time needed to administer the questionnaires varied, depending on the experiences of the respondent with fertility regulation. It ranged from about ten minutes, in the case of a girl who had not yet embarked on sexual relations, to more than an hour for a woman with many experiences of fertility regulation.

Interviewers

For the surveys with women, I employed several female interviewers. It was quite easy in Lagos State to find experienced interviewers who were fluent in spoken Yoruba and English and could write in English. I initially contacted
potential interviewers through networking and through the public health institutions where I had been working in the exploratory phase. Of decisive importance in selecting and training interviewers was their attitude. It was important that they had an open mind about induced abortion and other sensitive issues, and an open approach towards people of lower socio-economic status and towards traditional healers. I only wanted to employ interviewers who did not feel inhibited while discussing these sensitive topics. Many interviewers had to overcome their own initial taboos and feelings of embarrassment. Moreover, they had to radiate empathy for people and be able to adjust to the respondent’s mannerisms (in way of talking, approach, dress, etc) in ways that would make respondents feel comfortable. 17 Interviewers of TBAs had to show respect towards them and their practices, something that many biomedical staff had trouble with. Some interviewers possessed the required qualities ‘naturally’, some acquired them in the special training I conducted for the community surveys, while others could not adopt them and had to be dismissed as interviewers. Only females conducted the interviews with women, whereas a male interviewer was also employed to interview TBAs (who are predominantly male). In this phase, I contracted a co-researcher, Grace, a nutritionist (MSc) with extensive fieldwork experience, to co-ordinate the fieldwork in Epe. 18

The interviews with infertility clients, ANC clients and TBAs that had more qualitative questions than the interviews with women in the community survey were conducted by five experienced female interviewers and one male interviewer (for the TBA interviews), who were trained ‘on the job’. We trained five additional female interviewers to assist the more permanent interviewers in conducting the interviews for the community survey, because this had to be done in a limited period of time to make full use of expensive transport arrangements. 19 Grace and I supervised the interviewers during the community survey.

Validity of survey data

Besides the possible intentional underreporting of abortion by respondents, the definition of abortion used in this study might slightly distort the actual prevalence of abortion. The study definition of induced abortion is ‘all pregnancies that were reported by the respondents to have been aborted’. This definition could lead to unintended reporting errors in situations where women reported termination of a suspected pregnancy when they were not pregnant at all. Unintentional underreporting might also occur when the woman had a spontaneous abortion, i.e. miscarriage, after an unsuccessful attempt to terminate the pregnancy (20% of pregnancies normally end in spontaneous abortion). Pregnancy tests are not common among Yoruba women, and we did not ask interviewees
consistently if they had done one. These unintentional errors cannot be avoided, but the reported attempt is what is important to this study of abortion.

Other mistakes in reporting, partly unintentional and partly intentional, may be errors of recall (if they had abortion, when, how many, using which methods). I think the recall error is not large in this study because an abortion does not seem to be an experience that a woman easily forgets, even if it occurred years ago. For most women, abortion can be considered as one of the major events in her life, especially if it was a traumatic one. It is not a routine experience (except perhaps for the few women who had numerous abortions). Nearly all women who reported an abortion could immediately recall the year it happened (in the same way they remembered the years in which their children were born) and often even volunteered the month. Interviewers seldom got the answer ‘don’t know’ to any question, which is what one might expect when a respondent cannot remember what or when things happened.

Another problem in validity may arise if the study definition does not cover all abortions. This could be the case when the researcher and the interviewee define abortion differently. An example we encountered was that some women reported that they took methods, usually drugs, to bring back a missed menstruation. When these women were asked whether they thought they were pregnant or not, some of them said they were not sure. These women could have been pregnant and therefore the ‘bringing back of menstruation’ would medically be an abortion. These reporting errors could be either intentional, where the respondent used menstrual regulation as a euphemism for abortion, or unintentional, since she considered menstrual regulation to be different from abortion. The impression was that women did not use menstrual regulation as a euphemism for abortion, because the same woman who mentioned that she had had an abortion also mentioned that she had regulated her menstruation. When an interviewee did not term it abortion, the study did not count it as such. The numbers of menstrual regulation practices that could have been abortions were so small that they would not influence the overall picture of abortion.

I believe that in the present study, the structure of the data collection instruments and the high quality of interviewers contributed to low intentional underreporting. The impression of the interviewers that most women were willing to share their experiences of induced abortion reinforces the perceived validity. The problems related to abortion are increasingly acknowledged to be widespread, and women may have felt they could contribute to the solution of the problems by sharing their experiences.
Participatory action research

The participatory action research phase, which took place mainly from January to July 1999, was the most interesting and rewarding part of the study for me. The aim was to validate the survey data with different stakeholders by asking them whether they considered the findings to be true reflections of reality. Likewise, this phase intended to deepen the understanding of issues raised in the first two phases and to involve stakeholders in finding solutions to the identified problems, as well as informing and educating participants on topics they wanted to learn about. The study methods included feedback of the study findings, discussion of the findings, focus group discussions, group work, role-play, drama and story writing. All these methods intended to raise participants' consciousness of their individual and collective knowledge, opinions and practices. The methods also helped to make sensitive topics, such as abortion, more open to discussion. Moreover, these methods served to educate and empower participants by providing them with information and making them suggest for themselves what they can do about their needs and problems. Participatory sessions took place with groups of secondary school youths, members of communities in which the community survey was carried out, traditional birth attendants and biomedical staff and managers of Epe and Lagos.

Community seminars

We conducted five feedback sessions in the villages of Epe LGA where the community survey took place. These sessions were announced during the time of the survey, and in January 1999 a date for the 'community seminar' was set with each community. The community seminar lasted about three hours. The community leaders were asked to organise their community to attend, irrespective of whether members had participated in the survey or not. The sessions consisted of a presentation of the study findings to all who wanted to listen, after which questions could be asked. I conducted the presentation in English, which was translated into Yoruba by one of the health staff members. The big group then split up and we conducted focus group discussions (FGDs) with five different groups: women of childbearing age, women past childbearing age, men of all ages, girls and boys. In each group there were between 10 to 18 participants. The FGD participants tried to find explanations for, and gave different perceptions of survey findings, and discussed suggestions for improvements of identified problems of unwanted pregnancy, unsafe abortion and infertility. Facilitators and note-takers for the FGDs were five project staff (the five permanent interviewers) and five LGA health staff. Three of these LGA staff were those who
had been involved in the study since its initial stage in Epe; two were added from the health institution nearest to the specific community. The community seminars were well received by the community members and the LGA health staff. The enthusiasm and seriousness that women, men, girls and boys displayed in discussing the issues was the most notable aspect of the meetings. The community activities were big events for the villagers and researchers, which ended with drinks and snacks for the FGD participants, but which were enjoyed by the whole village.

**Workshops with traditional birth attendants**

Between February and May 1999, three one-day workshops took place with 30 TBAs in Epe, and three one-day workshops with 21 TBAs in Lagos. Most of these TBAs had been respondents in the interviews for the present study. The idea for these workshops arose after attending their monthly association meetings in which they expressed a wish for training. I thought it would be good to combine training with giving feedback on, and discussion of, the in-depth interviews and survey findings. So, morning sessions were intended to collect more information for the study, mainly on the TBAs’ perceptions and treatments for fertility regulation, and on their perceptions of and relationships with biomedical service providers. In groups, they discussed the topics and performed drama and role-play. Role-play and drama were intended to find out more about attitudes, behaviour, communication and referral between ethnomedical and biomedical providers, especially since both sides consider these to be problematic. TBAs proved to be extremely able in preparing and performing scenes of drama and role-play. The afternoon sessions were mainly for education on topics of their choice.

Facilitators for the workshops were the five project staff who had also conducted the interviews for the surveys. In Epe, they were supported by two LGA staff, and in Lagos, by two LGA health staff and one staff member from the Lagos Island Maternity Hospital. One of the reasons for involving these local biomedical service providers was to ease the generally poor relationship between ethnomedical and biomedical providers through creating more knowledge and understanding of one another. A fortunate outcome of the workshops was the improved rapport between the TBAs and the health staff facilitators, which had not always been good, as the following part of my research diary on the first workshop in Lagos indicates:
Starting was a bit slower than in Epe. People trickled in the room. When I came, three female TBAs were sitting there already. I was worried about the attitude of some medical staff, who did not even greet the TBAs when they came in. The medical staff grouped together at one table and the TBAs at the other table. I went to sit at the TBA table and when we started the programme I asked everybody to mix. Some did so reluctantly, but it eased the tension. One of the LGA staff commented at the evaluation session of the day with facilitators that he never knew that TBAs were so clean, which illustrates the prejudices.

**Sexuality club**

'Sexuality club' was the name the students of Ilupeju Secondary School gave to the education project in their school. The objectives of this education project were to explore students' knowledge and perceptions of sexuality and of practices of fertility regulation, to let them identify and analyse perceived needs and problems and to have them express how they would like their problems to be addressed. In total, we had eight sessions between February 1997 and December 1998. In 1997 I started to work with students of senior secondary school, class 1 (SSS1). Each of the 92 girls and 104 boys completed a self-administered questionnaire with open and pre-coded questions, which explored their knowledge and perceptions of sexuality, and also their level of mastery of English writing skills. The tool included some ‘finish the sentence questions’, inspired by Bleek (1976:168-177).

Originally I only had room for 50 students in the education project. However, it proved impossible to select students, because the majority of the nearly 200 students who had filled out the questionnaire wanted to be participants. So the group was split up, such that during a project day we did three to four shifts of one-and-a-half hours on the same topic. (This was the timeslot allotted to us by the principal, because we worked during school hours.) A session usually started with feedback and questions about the previous session. Then, after an introduction, the whole group broke up into subgroups to do group assignments. Students could choose whether they wanted to break up in mixed gender discussion groups or not. During the sessions, they discussed diverse topics including the problems of youths, contraceptives, sexual relationships, unwanted pregnancy, abortion and sexually transmitted diseases. They made a group report of their work. Each group chose a chairperson and reporter, facilitators were just around to clarify questions and keep time, not to lead the discussion. Some days, students were asked to fill a short self-administered questionnaire of just five to ten questions, through which we tried to establish the distribution of certain ideas that had cropped up in the group work.
The days ended with a lecture on a topic of their choice," which also paid attention to aspects I deemed necessary, such as unreliable contraceptive methods and unsafe abortion. The lecture was given either by a facilitator or by me. Students received handouts on all lectures. The four facilitators differed per session, depending on the topic. In three sessions we distributed a bulletin ‘Your questions, our answers’, which proved popular. These contained some of the questions that students had given me on a slip of paper. (I had advised them to do so, if they had a question they were too shy to ask in class, or for another reason did not want to ask publicly.) The last activities in the ‘sexuality club’ were a poster design and an essay writing competition. The students had to write a true or realistic story about a schoolgirl who had an induced abortion. This was an extremely useful tool, especially to find out how students become involved in sexual relationships, their feelings when faced with a pregnancy and whom they involve in their decision-making to abort. In total, the students wrote 106 stories.

Workshops with biomedical staff

The last data collection activity of this phase of the project was two one-day workshops with health staff, one in Epe and one in Lagos, which took place in June 1999. The goals of the workshops were to present the study findings, let the participants identify and analyse the problems and make recommendations on how to address them. The days started with participants filling out a self-administered questionnaire with questions mainly about their opinion of abortion under certain conditions and of contraception for certain groups of women. This served as a baseline to evaluate whether the workshop had made staff opinions change by the end of the day. After written and oral presentations of the study findings in the morning, the remainder of the day was for group work on these study findings, guided by prepared discussion topics on contraception, induced abortion, youths and TBAs. Groups chose their chairperson and note-taker.

Facilitators were four research staff who only clarified questions if needed, but were not involved in the group discussions. Participants in Epe were 24 staff members of the State general hospital and of the LGA health office and health centres. In Lagos, 22 staff members participated from Lagos Island Maternity Hospital and Onikan Health Centre, (which had been locations to interview clients in the survey phase), and from the LGA health office and clinics. These staff were midwives, PHC nurses, health assistants, matrons, community health officers, health educators and medical doctors of various levels, including managers.
Community seminar: Focus group discussions with women and with men
Community seminar: Focus group discussions with girls and with boys
'Sexuality club' in Ilupeju Secondary School: Groupwork
Top: Workshop with traditional birth attendants in Epe
Bottom: Workshop with biomedical staff in Lagos
Sexuality club: Poster made for poster competition, by Atinuke Farogbon
Case histories

During all three phases of the fieldwork, I recorded case histories, but in the two last phases, June 1998 to July 1999, this was done in a more systematic way. Bi-weekly, Comfort or I checked at Lagos Island Maternity Hospital to see whether any women had presented with complications of induced abortion. Mrs. Ekundayo, a midwife from Lagos University Teaching Hospital who has been involved in other abortion studies, also recorded some case histories in Randle Comprehensive Health Centre, a public health centre. We interviewed all women with complications who were still in the hospital, for a total of 41 interviews. The interviews were often done in a series of sessions, depending on the seriousness of the case. We used English or Yoruba for the interviews, but all reports were written in English. Although I had asked the interviewers to use the wording of their respondents, in their (translated) reports, some medical terminology still slipped in because of their midwife training. I have decided to present the case histories in the first person, although not all of the quotes were recited as such because we did not tape the interviews and, as already explained, some interviews had to be translated from Yoruba into English. Nevertheless, I have tried as best as possible to capture the words, expressions and tone the women used during their interviews. I made this stylistic choice because the use of the first person makes the histories more personal and immediate than they would have been if presented in the more detached third person.

The case histories recorded in the hospital were intended to get more detailed, recent and in-depth information on abortion experiences. These cases are neither representative of all abortions in the community, nor of all abortion complications. The survey data of the present study indicate that certain groups of women aborting have complications more often than others, due to the abortion methods they used, and moreover, some groups stay at home when they have complications, whereas other women go straight to the hospital.

Although women with abortion complications in the hospital were usually quite willing to share their experiences, it was not always easy to get their histories (see Box 2.3). Sometimes I felt uneasy about intruding in someone’s life and preying on someone’s misery. Sometimes women were reluctant to talk about their experiences that had brought them to such a deplorable state. The biggest difference with the past abortion experiences recorded in the surveys and those taken at the hospital was that here, the complications were recent experiences. The woman had to cope physically and emotionally with the problems at that moment in time. Their stories often made me feel helpless and angry.
Box 2.3. Research diary

Friday, 2nd October 1998
Chief matron Mrs. Ayodeji had already prepared me by telling me that there was a girl with a very serious abortion complication who had come in on Monday night: She had a perforated uterus and recto-vaginal fistulae. She is a secondary schoolgirl of 16, Yahaya. I visit her in the C3 ward. She is sitting saged in a chair, looking very miserable. She has a drip, a catheter and a tube in her nose; the table beside her bed is full of medicines in bottles, boxes and strips. She can hardly talk - but it seems she wants to talk to me. I talk with her for some ten minutes. Her English is quite good. I then decide to stop and continue another time when she feels a bit better. She has so much difficulty talking with the tube in her nose. Mrs. Ayodeji tells me later that the surgeon has not been around yet and that they just did some ‘emergency repair’ for the girl. I feel so sad when I see the girl, a typical story and the worst you can get. She was four-and-a-half months pregnant when she realised that she was pregnant. She did not want the baby, because she was still in school, SSS2. She went to a private hospital, nine days ago, that she knew about from a friend. She had a D&C done. She went to LIMH after being transferred from another private hospital where her father had brought her because she was passing faeces in her urine. She said her father knew what had happened after he heard about the faeces.

Monday, 5th October 1998
Yahaya is lying in her bed, looking better, but still weak. She looks angry, bewildered. She still has all the tubes in her neck and arm. Her sister has just come with a boxful of medicines for her. Yahaya does not seem happy to see me at all, the opposite rather. Maybe now she realises more what has happened to her than when she had just been admitted. I feel embarrassed looking at so much misery and do not want to add to it by asking her questions if she does not want to talk. I tell her I will come back another time. The matron in charge of the ward had told me that she would not be discharged or transferred soon.

Thursday, 8th October 1998
Yahaya is lying in her bed, weak. The doctors did all the ‘repairs’ for her, as far as they could in this hospital. Maybe now she needs to go to the general hospital, she says. She seems to be preoccupied with herself and her problems (which I understand of course) and is not forthright when talking to me. I try to talk to her and motivate her, but she is still not communicative. She answers with ‘yes’ or ‘no’ or ‘don’t know’. She seems bored and not interested. She also has difficulty talking. In her neck is still the opening for a drip. I feel so sorry for her. I do not want to bother her, but still I want to hear her story. I try to motivate her by telling her about my work with the students of Ilupeju School. How important it is to hear the personal experiences of young girls like her who had an abortion. How in this way she can help to prevent the same thing from happening to other girls. I ask her what she heard from her parents and teachers. ‘They told me to stay away from boys and did not tell me anything else’, she says almost aggressively. I feel so angry, too, and helpless, I cannot do anything for her. How is it possible to fight against ideas that are so strong? But then these have to change, because they bring so much preventable misery! I explain to her that I do not want to force her to talk and that she is free to tell me that I should not come and ask her questions again. She is reluctant to answer, but I repeat the question. She softly says I should still come back. And I feel happy. I also realise that this may not be her true feelings, but it is enough for me to come back another time.

[I did not have the chance to see Yahaya again. The next time I came to the ward in LIMH where she had been, about a week later, Yahaya had been transferred to the general hospital in Ikeja, another LGA of Lagos metropolis.]
Data analysis

Data analysis and interpretation had to be ongoing throughout the study, as this was inherent to the gradual development of the study methodology. I analysed and interpreted qualitative information of the exploratory phase (written in daily reports) to be able to develop survey instruments.

In the survey phase, Biodun and I wrote qualitative information in compilation sheets. Some of this qualitative information I then categorised and coded. Grace and I did the coding on the questionnaires. I employed two data entry persons, Ifeoma and Fatima, who worked on the computer in my house to enter coded qualitative information and quantitative data in EPI-Info data files that I had constructed. Each survey and additional questionnaire had their separate data file, some of them linked. I calculated associations between variables and set the significance level at 1% rather than 5% to compensate for the non-random sampling we employed. With some of the findings I still present possibly significant associations, at p-values up to 0.05. Before we started the participatory phase, I had finished a first analysis and reporting of all survey data. The following 'case' from the present study illustrates how important it is to combine qualitative and quantitative data collection to be able to derive at valid conclusions:

In exploratory interviews with women, some women who had one or more abortions told me they did not use modern contraception because they preferred abortion. They had this preference because in this way they would show to their husbands that they were still fertile and, as they believed, therefore still attractive; their husbands would not have a reason to take another wife. The women talked about their abortions very openly and almost seemed to be proud to have had so many. Based on these exploratory interviews, I constructed the preliminary theory that for Yoruba women pregnancy per se is not unwanted, but the birth of a baby is unwanted (Koster-Oyekan 1999:24). However, after interviews during the surveys with about 650 women who had abortions and soliciting the opinions concerning abortion of more than 500 women, I had to withdraw this theory. The view women expressed in the exploratory interviews proved exceptional; I encountered it just a few times more.

I used the report of the first analysis of the exploratory and survey phase for feedback for the different participatory sessions. Let me indicate here that only in the stage of final data interpretation and the writing of this book, did I let 'abortion' play the leading role. Of course the problems that initiated the study were unsafe abortion and abortion deaths, but throughout data collection phases and especially in participatory sessions, I paid equal attention to contraception and infertility.
Biodun and Ifeoma entered most of the huge amount of qualitative information derived from the participatory sessions by hand in compilation sheets. Grace helped me with a first interpretation of the qualitative findings. Based on this first interpretation of all field data, I wrote a popular booklet on the whole study *Fertility regulation among the Yoruba* (Koster-Oyekan 2000), which was intended for the participants in the study and for interested persons of Nigerian and international organisations.

**Limitations**

There are some limitations and biases inherent to the study methodology. As explained, the research was biased towards the poorer part of Yoruba society, because the problems of abortion mortality were believed to be higher among the poor. However, since the majority of Yoruba (as do all Nigerians) belong to the poorer parts of society nowadays and the rich are the exception, this bias would not distort the general picture of abortion in Yoruba society.

Another bias is that I only conducted the study in public health institutions and clinics of traditional birth attendants, not in privately owned biomedical hospitals. This was partly because of the difficulty in getting access to private institutions, (we tried several times), whose doctors might not want to expose the fact that they perform (some) illegal services. The other reason was time constraint; we were fully occupied with other study activities. However, since, as I already indicated, with ANC services and infertility services, many women use different providers at the same time (public, private and traditional), not interviewing clients in private institutions would not have biased the findings considerably. Another limitation is that not all data collection methods took place in both rural and urban areas. We only conducted FGDs with community groups in Epe, whereas the education project with secondary school students and interviews with women with complications of induced abortion occurred only in Lagos. This was not intentional, I only realised it to be so after the final data analysis. However, since the study used triangulation of data collection methods, this unintentional bias was not an insurmountable problem. On the various sub-topics, I have sufficient information from different data collection methods to be able to make comparisons between urban and rural situations.

A further limitation is that I might not have paid enough attention in exploring the views and experiences of men. I had FGDs with male groups, about half of the secondary school students were boys, and most TBAs are males, but no in-depth interviews or surveys were conducted with men in the community. One explanation for concentrating on women in the data collection is, of
course, that only females can physically experience abortion and its physical complications. Since this is an applied study of a health problem, with intentions to give recommendations about how to solve the huge problems related to and resulting from abortion, I approached the problems from the lived experiences of women, and therefore mainly interviewed women. In their histories they also describe whether and how others, including parents, husbands and partners featured in these experiences. Interim analysis of findings showed that induced abortion is usually a decision by a woman without the involvement of her partner. I allowed myself to be guided by this non-involvement reported by women and excluded any questions about men’s opinion on it. Thus, although I did pay attention to the males’ perspective and their involvement in abortion matters, this was in general, not inquiring after their personal experiences with possible abortion of their girlfriends, wives or daughters. However, because the experiences of women are contextualised in the prevailing gender relations, it is not ‘just’ a study of women, but of females as a gender, i.e. in their relations to men.

Reflections

In critical anthropology, of which this applied study is an example, the researcher should reflect on and make explicit her/his position, including paradigmatic standpoint and relationship vis-à-vis the subjects, because this position will influence data collection during fieldwork and will inevitably colour the ethnographic writing (see also Lamphere et al. 1997:5).

To make my position clearer, I want to end this chapter with reflections on quotes of my two study supervisors that relate to the methodology of this study and to my position within the research. Van der Geest (1998:52-53) wrote, ‘Each fieldwork experience and each interpretation of data is filtered through the mind and heart of the researcher’ and ‘... expressing personal views and feelings may reach a deeper level of mutual understanding and appreciation [between researcher and researched]’. I have attempted to make explicit how in this study of abortion I tried to be open in my mind by not having assumptions that would bias data collection and interpretation. However, I was not impartial, my heart was always with and on the side of the women who suffered from problems related to abortion. As a wife of a Yoruba man, I shared many of the experiences with my informants as far as relationships with husbands and in-laws are concerned, and could therefore understand their situation better than if I had not been part of their society. The in-depth interviews I conducted with Yoruba women were especially characterised by an exchange of experiences rather than just a question and answer session. My positions were multiple,
referring to my sense of identity as well as how others would look at my position. Sometimes my many roles as outsider, insider, researcher, friend, trainer, employer, family member, wife, member of the royal family, mother and white woman conflicted, and I had to juggle the different roles to suit the context. Even within my role as a researcher I had different roles: quantitative, qualitative, trainer and health educator.

I have been questioned on how the fact that in participatory sessions I also ‘intervened’ by giving health education influenced the information given by participants. For various reasons, I think the effect is minimal. Firstly, I tried to circumvent any bias by scheduling the education part at the end of sessions, after I had explored knowledge and ideas concerning specific topics. Secondly, especially with traditional birth attendants, the preferred lecture topics were not those of this study. Thirdly, interviewers answered the questions of informants (for example on contraceptives, and infertility problems) as much as possible at the end of the interview and possibly referred to appropriate services. Even if the education and information we provided slightly influenced the collected data, I think this has to be accepted, because not giving information to participants would be ethically wrong. Corlien Varkevisser, my other supervisor, pleaded for this approach when she talked about participatory studies in AIDS, which combine data collection with intervention. She stated: ‘Face to face with a fatal condition, one cannot stay impartial’ and ‘Informants who express a need for information, counselling or treatment can be referred to services’ (Varkevisser 1998:90). In the present study the giving of information and the reaction of participants to it were part of the research process.