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Secret strategies: Women and abortion in Yoruba society, Nigeria

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Publication date
2003

[Link to publication](#)

Citation for published version (APA):

Koster, W. (2003). *Secret strategies: Women and abortion in Yoruba society, Nigeria*. [Thesis, fully internal, Universiteit van Amsterdam]. Aksant.

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ABORTION, RULE AND REALITY

This chapter will show the divergence between the rules related to abortion and the reality of it. Such a divergence is not abnormal; as was already discussed in Chapter 1, the practice of persons will not always follow their society's rules for proper behaviour. Individuals or groups of persons may, intentionally or unintentionally, routinely break the rules. Either they may consider that what is deemed appropriate is not in their personal interests, or emergencies may arise in which they see breaking the rules as the best way to cope with the situation. In this chapter, I describe on the one hand the opinions of the community about abortion, and on the other hand the prevalence thereof. This discussion sets the context for Chapters 5 and 6, which deal with individual abortion experiences of single and married women. Their accounts will explain *why* women might break the rules.

Sources of information

The informants who helped to paint a picture of the societal rules concerning abortion were women, men and youths in the community, secondary school students and ethnomedical and biomedical service providers. They gave their personal and group opinions on abortion and women who abort (see Table 4.1)

The reality of abortion is derived by calculating the prevalence of abortion among women in the community survey. The rate of unsafe abortions is based on personal stories of women with abortion experiences who survived abortion, and from the histories about women who died. Thus, I analysed induced abortion from two perspectives: using the individual woman as a unit of observation and using the induced abortion itself (see also Zamudio et al. 1999:413). For example, the rate of unsafe abortions and complications are calculated over all recorded abortion experiences, while the prevalence of abortion was figured with all interviewed community women as the denominator.

Table 4.1. Sources of information for Chapter 4: Abortion, rule and reality

<i>study population</i>	<i>data collection method and sample size</i>
<i>for rules regarding and opinions about abortion</i>	
Older women, younger women, men, girls and boys	Focus group discussions: 5 with each of the adult groups, 7 with boys and 7 with girls
Secondary school youth	Group discussions and group work
Women in the community survey and ANC survey	Open questions (N=714)
Biomedical staff	Group discussions and self-administered questionnaire (N=46)
Traditional birth attendants	Group discussions and in-depth interviews (N=42)
<i>for practice of abortion</i>	
Women with past abortion experiences	Semi-structured interviews (N=652*)
Women in community survey	Semi-structured interviews (N=652*)
Women in ANC survey	Semi-structured interviews (N=367)
Women in the hospital with abortion complications	In-depth interviews (N=41)
Histories about women who have died from abortion (told by women in community survey)	Semi-structured interviews (N=106)

* It is a coincidence that the numbers are equal (see Table 2.4)

Public opinions about abortion

It was not surprising that the first reaction of most persons when we asked them what they thought of abortion was usually an outright, 'It is very bad'. Of the 714 women we asked in interviews, 85% voiced negative opinions about abortion, and so did nearly all participants in the focus group discussions and group sessions. Women interviewed in Epe (the rural area) were relatively more negative about abortion (90%) than in Lagos (urban area), where 81% of interviewed women had a negative opinion. They may condemn it less partly because relatively more women in Lagos had experienced an abortion. It cannot be deduced whether these women had an abortion because they had a less negative opinion, or if it was the other way around, that they were less condemning because they had had an abortion. I am inclined to believe the latter is true (provided they did not experience complications after abortion). Yet, the majority of women who had an abortion were negative (73%), which proves the strong negative feelings. Among the women of different religions, the *Aladura* were the least negative about abortion (78%), perhaps because the *Aladura* church is generally the least dogmatic among the churches. Married and single women were equally negative about abortion. Only 7% of the married women interviewed had positive opinions, compared to 4% of the single women. Single

women had more mixed feelings, maybe because, although they think abortion is bad, they know that many single women resort to abortion as a solution for an unwanted pregnancy.

Moral objections and health risks

This quantitative information, simply knowing the distribution of the negative and positive views on abortion, does not suffice as an answer to the question, 'What are the public opinions on abortion?' We need to know *why* persons think abortion is bad (or good). They could have a negative opinion because it is against the law, because it is against their religious beliefs or moral convictions to kill a potential life, because abortion is a risk to the woman's health or for other reasons. It could be potentially more stigmatising for a woman to act against religious or moral community norms (if she is discovered) than if she would be considered to 'just' be risking her own health and life. Therefore, if there are strong moral and religious convictions against abortion, women might not so readily share their experiences with others. Some of the respondents' common statements illustrating moral and health objections are found below:

Negative health consequences of abortion:

It is a dangerous thing to do. Complications can follow: infertility or death.

It is risky, because one may remain barren for the rest of one's life.

It is very dangerous, because the woman can die in the process and that is the end of her.

It is not good at all, it can affect one's reproductive system and you know how we attach great importance to children here.

Moral objections against abortion

It is not good, because prevention is better than cure, and the cure in this case involves taking a life.

It is not good; it is like spoiling the work of God.

It is sinful. God says you must not kill. So why not leave the poor child to come and enjoy life?

If her own mother had aborted her, would she be alive by now?

Combination of health and moral objections

It is not good, it kills and it is a sin if you go about with men and you commit abortion and you die. Then you have killed yourself.

Risk of death appeared to be the single most commonly mentioned objection against abortion by women in Epe (37%) and even more so by Lagos women (44%), but also the 'risk of infertility' scored high, 24% in Epe and in Lagos. The threat of infertility that will have negative social consequences for the rest of her life is very real to all Yoruba women. As discussed in Chapter 3, a woman without a child does not count as a 'complete' woman in Yoruba society. So a woman aborting her first pregnancy who is not able to conceive afterwards will have to carry the life-long consequences. The consequences of secondary infertility for a married woman who already has children may be different, but may also be problematic (see Chapter 8).

Moral objections refer to the religious doctrines (of all religions) that condemn abortion as a sin against God (mentioned by 31% of women) or refer to abortion as being equal to murder (reported by 18%). None of the community women mentioned federal laws as a reason to be against abortion. They probably did not know about them, since the anti-abortion law is rarely enforced. Moreover, Nigerians generally have learned that many laws are erratically enforced and thus do not play a big role in an individual's decision-making process.

An interesting, unexpected finding was another category of objections against abortion, which relate to the traditional religious beliefs about predestination of the number of children that a woman will bear. These are illustrated in the following answers of respondents who thought abortion is bad:

The woman may abort the only child or children given to her by God. We will not know which child was going to be great in future.

Supposing she is destined to have only one child, after aborting it, all she will now be saying is that witchcraft is haunting her [whereas the respondent believes that in reality she has exhausted the quota of children she was going to have].¹

If a baby is aborted, that baby will never come back to the mother again, because the spirit of the child will be annoyed.

As was explained in Chapter 3, many Yoruba continue to believe in predestination. Yoruba traditional belief holds that at birth, a woman has a predestined number of children in her womb, and what each of those children is going to become in his or her life is already fixed. Yoruba also believe in reincarnation of deceased lineage members into the same lineage. Thus, by aborting a pregnancy, a woman interferes with both her and the unborn child's destiny. This can have very negative consequences, including childlessness or missing a chance for wealth in the future, because the aborted child was destined to be someone important. However, although many Yoruba believe in predestination and reincarnation, just a minority (4%) objected to abortion on the basis that a woman interferes with her destiny.

Combining all answers (women could give multiple answers), negative health consequences are the main concern against abortion. Roughly half of all women (52%) who had negative opinions about abortion stated *only* negative health effects as a reason and less than one third (31%) had *only* moral objections. Table 4.2 summarises the answers and shows the differences in concerns between single and married women in Lagos and Epe.

Table 4.2. Reasons given by interviewed women for their negative opinions about abortion, by location and marital status

reason for negative opinion about abortion	Epe			Lagos			all		
	married (N=202)	single (N=41)	all (N=243)	married (N=249)	single (N=95)	all* (N=346)	married (N=451)	single (N=136)	all* (N=589)
Health complications	46%	61%	49%	51%	65%	54%	49%	64%	52%
Moral objections	34%	29%	33%	31%	23%	29%	33%	25%	31%
Combination: health and moral objections	12%	7%	11%	14%	5%	12%	13%	6%	12%
Not good to interfere with destiny	3%	—***	3%	2%	5%	3%	3%	4%	3%
Other combinations**	5%	—***	4%	2%	—***	1%	3%	—***	3%
Total ****	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: community and ANC survey combined

* For two women, marital status was unknown

** Health and destiny, moral and destiny and other

*** Only one woman gave this answer

**** Some figures do not add up to 100% due to rounding

In both research areas, single women were significantly more concerned with the negative health consequences than married women. This is not surprising, because the consequences of infertility due to abortion, the second most commonly stated perceived health risk, are more severe for single women than for married women who already have a child. Moreover, they probably have seen many of their peers suffer from health complications after abortion. Compared to married women, single women in both Lagos and Epe had fewer moral objections.

In view of the stated goal of finding solutions to abortion problems, it was a positive finding that fear of negative health consequences was the main objection to abortion, and not moral convictions. Persons who have strong moral convictions are usually less inclined to discuss and view problems from different perspectives. People who recognise problems as health-related will generally be more receptive to changes that could improve these unhealthy situations. For service providers, the chance that interventions against unsafe abortions would meet a listening ear therefore appears more positive.

Mixed feelings

It is not always easy to give a straight answer to a question; 8% of the 714 interviewed women were openly ambivalent and saw bad *and* good aspects of abortion. These women regarded abortion as the best alternative in a given situation, although they still disapproved of it. The highest percentage of women who had a mixed opinion (14%) was found among the group of women who had had an abortion. The majority of these women were of the opinion that it was a bad thing they did and a sin before God, but that they were forced to do it by the circumstances they found themselves in. These circumstances overruled their morals and fear of health risks, as the following quotes illustrate:

It is a sin that I committed, but I still had to do it. May God forgive me. I prayed for forgiveness from God. (21 year-old married woman, who aborted when she was 19 because she was single and she and her partner had no money)

I did not like it at all, abortion is very painful and dangerous, and women can die from it. Circumstances pushed me into doing it. (25 year-old married woman who aborted this year because her husband did not have a job at the time, and they did not have money to raise another child)

It is a sin before God, but parents make it hard for their daughters who get pregnant to keep the baby. I would also abort if I found myself pregnant. (18 year-old single apprentice who did not have an abortion)

A 40 year-old married schoolteacher, who had four abortions, expressed her opinion more philosophically: 'It is not good to destroy what God has done, but morals also depend on reasons and conditions. When there is no money or when nobody claims the baby, it is better to abort.'

Best solution

Compared to the number of informants with negative opinions on abortion, informants with relatively positive opinions were few, comprising just 6% of the 714 responses. However, it is important to identify why some women were positive, because their opinions could be a guide for creating more understanding and openness in the discussion about abortion. Women offered different reasons:

It is not really a bad practice; it may be the only option at that moment. What is the point giving birth to a child that one cannot cater for? (30 year-old married woman in Epe, who has not had an abortion)

I do not see anything wrong, because if your other child is still small and you become pregnant, the unborn baby can kill the one before it. (40 year-old married fashion designer in Epe who had three abortions during her marriage)

If you are single and from a polygynous home and you get pregnant, the other people in the home may laugh at you and your mother. (18 year-old single girl, who at the time of the survey had an unwanted pregnancy that she had tried to abort)

It is unfair to bring an innocent child to the world to suffer for no just cause, especially if there is no money to cater for him. (21 year-old single woman in Lagos who had just aborted an unwanted pregnancy because she and her boyfriend did not have money)

I do not think that abortion is a bad thing. There could be so many circumstances that would disturb someone to have a baby and take good care of it. There may be no money, the mother may not be in good health, the other child may still be small or she has other plans with her education. One should be properly ready for a baby. I have done four abortions, two before I got married and two during my marriage. (40 year-old married schoolteacher)

It is not bad, because some girls may find themselves trapped when their boyfriend does not accept the pregnancy. (27 year-old married trader who had two abortions during her marriage)

Abortion is good if you still want more children, instead of family planning that will take a long time before I can get pregnant. (34 year-old married businesswoman, a university graduate, who had two abortions when she was single)

The main reported reason for being positive about abortion was that it provides a solution when a woman is faced with an unwanted pregnancy for whatever reason. The respondents foresaw serious problems when a woman is forced to carry an unwanted pregnancy to term. She may have to face the public disgrace of being pregnant from a (secret) pre- or extramarital affair, financial problems, the inability to take care of the child, and/or the end of her education. Just three women had another type of reason for being positive, as illustrated in the last quote: They considered abortion as a method of birth control and said to prefer it to regular contraception, because they thought contraception had too many side effects, including delayed fertility or infertility. Apparently they were not aware that unsafe abortion carried similar risks.

Acceptability of abortion under certain conditions

The majority of interviewed women and participants of group-sessions who were unconditionally negative about abortion did not differentiate between any extenuating circumstances; they simply condemned abortion in all situations. Those who had mixed feelings or were relatively positive about abortion were more open to certain circumstances of unwanted pregnancy, in which case abortion would be considered acceptable.

Why pregnancies under certain conditions are unwanted will differ between societies, groups and sub-groups. As one will recall, in some parts of Yoruba land, mainly among poorer families, a woman is expected to prove her fertility and usefulness for the patrilineage *before* her fiancé will marry her. In most other social environments, pregnancy before marriage is condemned and, by definition, unwanted. Among Yoruba, a pregnancy that comes too soon after another is always unwanted. When the same happens to a woman in Western Europe, she may welcome the pregnancy because she feels it is better to have the children close together. The children will have a playmate at home and it enables her to accelerate her re-entry into society in pursuit of a career.

In the focus group discussions and group work with women, men, youth and ethnomedical and biomedical service providers, we discussed the circumstances which would make a pregnancy unwanted, how a woman would feel, how the society would react and their opinions about the acceptability of abortion in these circumstances. I was struck by the paradox of the participants' thorough understanding of the circumstances under which pregnancies may be unwanted, and, at the same time, their rigorous conviction that women in most of these circumstances should not abort, but have the baby. Only in cases of rape or when the father of the unborn baby died was abortion acceptable. In both of these cases, the woman had an unwanted pregnancy because of circumstances that were beyond her control and, therefore, her fault.

Rape

The stories of rape that I heard (from women's personal experiences and from stories told by others) were mostly about girls who were either raped by a gang of (school) boys, by a teacher or by a family member who was not related to her by blood (a step-father or a step-brother). Rape of married women was said to be mostly committed by armed robbers. Even after rape, the family of a single girl will try to get the man take his responsibility and let him acknowledge the pregnancy, that is, if the person is not a family member or an armed robber. If nobody takes responsibility, a child born from rape will be regarded as a bastard and will have problems in future, because (s)he does not belong to any known

patrilineage and may become an outcast in the community. Thus, when a single woman has been raped and the man who raped her is not known, the majority of participants in FGDs and group sessions with health staff considered abortion acceptable and even advisable. A married woman pregnant from rape by armed robbers should always get an abortion. However, some participants warned that abortion is always risky. One group gave the example of a newly married woman who had been raped by armed robbers. She got pregnant, and the husband advised her to abort the pregnancy. The electricity generator in the private hospital went off while the doctor was performing the abortion, and she died immediately. The couple had been married for only three months.

Death of the partner

Another more or less acceptable reason for abortion, though mentioned less frequently than rape, is the death of the man responsible for the pregnancy. When a woman is pregnant and her husband or fiancé dies, the family of the man may insist that the woman abort if they feel that they cannot or do not want to cater to the woman and her child. This may occur if the husband's relatives suspect that she is responsible for the man's death. People will always look for persons having caused an untimely, and therefore unnatural, death. When a young husband dies, her in-laws will often point to the wife as the culprit. However, others believed that the woman should not abort, because she should consider the child as a 'gift' to replace her dead husband. Children born after their father dies are given names that will remind everyone of the circumstances under which they were born, like Ekundayo (my sorrow has turned into joy), Enitan (a child of history), Babatunde (father has come back) or Duminiu (gladden my heart).

Too short of birth interval

A pregnancy that comes too soon after a previous baby is normally considered unwanted for a Yoruba woman, since the ideal spacing between children is two years or more. A woman who has her children too close usually becomes the subject of gossip and abuse. People may call her all sorts of names, such as *aṣewo* (whore), or *agbere* (harlot). They may compare her to fertile animals who have lots of offspring, such as pigs (*elédé*), or mock her of being too fertile: *iya botinsin lo mo n jabo* (a child is delivered as she sneezes). They may also accuse her of purposely endangering the life of her baby: *iya olomolapere* (a mother that puts her children in the basket). People consider her as undisciplined, without self-control, impatient and not able to abstain from sex. They may taunt her that she would rather give her breast to her husband than to her baby, believing that when a lactating mother has sex, the man's sperm will spoil the breast milk.²

Despite all of the social sanctions, a woman who gets pregnant too soon after having a baby may not mind what the community says as much as she is concerned for her own well-being and that of her children. She may be too tired to go through another pregnancy and delivery again, so soon after the previous one from which she has not yet recovered mentally or physically. She may also consider the health of the preceding baby. A new pregnancy will take her full attention and care away from the baby who was just born. She may not have enough breast milk for this child because the flow of breast milk diminishes with another pregnancy. As a consequence, the baby could become malnourished and sick. She may also have financial considerations; having a small baby *and* a pregnancy at the same time may distract her from her work or business. The stress of an unwanted new pregnancy may be so much that her breast milk does not flow and she will have to buy baby formula that she cannot afford. Or she may think ahead and know that there will just not be enough money to raise another child. All these reasons are acknowledged, but very few participants in FGDs sympathised with the decision of such a woman to abort, and just one-third of biomedical health staff did. The majority were of the opinion that she must have the baby and endure the burden. Only a few people pointed to the risk that the children would suffer, and that they might even die because the mother would not be able to care for both small children.

A group of older women added that in the past, if a woman got pregnant when still nursing a child, there was still another solution to the problem (other than 'enduring the stress' or abortion). Such a woman could take a special charm from the herbalist that would 'stop' the growth of the pregnancy. When the woman was ready for another child, the herbalist would remove the charm, after which the pregnancy continued to grow. Traditional birth attendants confirmed that such a charm existed.

Financial problems

Married couples increasingly realise that an additional child may drain the financial resources of the family. As described in Chapter 3, for the majority of families in Nigeria, the economic situation is becoming increasingly critical. An additional child will impede the education of the older children, for whom there is already not enough money to pay for their school fees. Yet paradoxically, children are always considered an investment and financial resource for the future, even if they remain uneducated, although education adds to the investment. For single women and their partners, the prospect of having a child without being financially 'safe', is often the reason to abort. Community members however, were of the opinion that a lack of money should never be a reason for abortion. They believed that God would provide for such a child, 'God who allowed the

pregnancy to take place will also take care of the child'. Biomedical health-care providers both in Lagos and Epe and ethnomedical providers in Lagos (but not in Epe) proved to be more understanding of women aborting for financial reasons: about half of them agreed with abortion under such circumstances.

Extramarital affair

A pregnancy from an extramarital affair is a threat to the wife's position in the lineage of her husband and to her relationship with her husband. A husband will never accept a child from another man produced during his marriage. He may only accept and adopt a child whom the woman had before he married her. Despite these risks, some women have extramarital affairs, mainly for financial reasons. As discussed in Chapter 3, the wife is financially responsible for the upbringing of her children to a large extent. As such, nearly all Yoruba women must earn money, some in formal employment, but mostly as small traders. Having lovers and sex for money is one way of supplementing the family income. The statement of a TBA who performed abortions is illustrative:

Although my heart is not with it, I have to help women who are in need and who have a genuine reason for not wanting a pregnancy. A student who has to finish her exams has to come with the man who made her pregnant. I also help a married woman whose husband has travelled and who had sex for money to take care of her children and then got pregnant.

Women may also have extramarital affairs because they like sex or because they have fallen in love with a man, 'They are just like men who want to have sex with a pretty girl'. Whatever the reason women have for an extramarital affair, they will never find sympathy from their husband or in-laws if it is found out that they have delivered a child from such a relationship. Community members and health staff said that they understand a woman's wish to abort such a pregnancy, but they would never sympathise with her. They consider approval of the abortion as approval of the extramarital affair.

Premarital affair

Premarital pregnancy is usually unwanted. It is a sign of disrespect of the traditional taboo on premarital sex. Community members said that an unmarried woman who is not engaged and gets pregnant will be gossiped about in the community; she will not be respected, and is considered a prostitute. She may be given nicknames such as *dalemosu* (she who gets pregnant in her father's house) and her child will be nicknamed *mojere* (inherited). People believe she has spoilt herself and may become a liability to her parents. However, her status also depends on how she behaves after she has the baby. If she keeps herself well

and lives with her parents, she is not stigmatised as much as when she lives on her own and 'jumps from man to man'.³

Pregnancy when a girl is already engaged is not frowned upon as strongly, except when the couple has a strong Catholic background. One will recall that in some groups, pregnancy is even a condition for marriage. During the field-work in Lagos, engaged women often told me that they were 'looking for pregnancy', because only when they would be pregnant (some said only when they would have delivered the baby) would their fiancés complete the final marriage arrangements. Only then would they be allowed to move into their future husbands' homes.

Even if a girl does not mind the gossip of the community, she may foresee problems for herself as an unmarried mother, because it may be more difficult for her to find a good marriage partner. The FGD participants shared their views on the chances of an unmarried mother to get married. Views differed between groups of women, men, girls and boys, and even the opinions among the women were divided. Some women said her chances were as good as a woman without a child, provided she had behaved well after having the child and preferably had lived under her parent's roof so that she could be monitored. Other women foresaw that such a woman would carry the stigma all her life and men would not like to marry her. Alternatively, she would be 'cheap', because the husband would not have to fulfil the normal financial marriage obligations (paying the full bridewealth).

The men in the FGDs said whether they would like to marry her or not it depended on the circumstances of how the woman became pregnant. It should be investigated whether the father of the child has totally 'released' her and the child, or not. If he has not, the marriage may be dangerous for the new husband, as the father of the child might be jealous and try to harm him. Some men do not want to financially support a child which is not their own. They may remain jealous of the previous relationship the woman had.

On the other hand, some men like to have more experienced women, who know how to take care of children and the household. They see a woman with a premarital child as an asset who will give birth to more children for him. Several times, community members stated that such a woman might even bring luck to other wives of a man who could not conceive (see Chapter 8). A male member in a FGD told a story to illustrate this point:

The wives of my older brother could not conceive. He went to an herbalist and was advised to marry a woman who had borne a child already, if he wanted his other wives to have children. It was not until he married this woman that his other wives started to have issues [children].

Judging from the opinions of the adult informants, it seems that having a child before marriage does not necessarily spoil a woman's chances of finding a good husband, but could make it more difficult. However, boys and girls generally had more pessimistic views about the chances of a girl with a child to get married. Many of the schoolboys, who were about to embark on their adult lives and had not yet married, said they would not like to marry a girl who had a child already. Boys expressed fears that the father of the child might harass them and even try to murder them. They also did not want to be financially responsible for children who were not their own, nor run the risk that the father would later return to claim the children as his own. The boy's own family might be against it as well, because if the woman would not bear a child for her husband, the premarital child, who is not a lineage member, would be the one to inherit the family property. Boys also feared the abuse of their friends, who would mock them and call them 'wife snatchers'. Additionally, there would always be the uncertainty about the character of the woman. Since she was irresponsible once, she may behave irresponsibly again, perhaps in other ways. Only in one of the seven FGDs with boys, did the majority say they would marry such a woman if they really loved her. However, investigations would always have to be done as to what led to the pregnancy: She might be of good character, and the pregnancy was just a mistake or not her fault at all. Circumstances favourable to marriage that the boys mentioned were that the girl's father was rich and supportive, and that she would have a wealth of experience with childcare. Some boys also saw it as an advantage that the girl would already have experience in sexual relationships and therefore sex with her might be more satisfying than it would be with a novice. (Probably they were novices themselves, and uncertain about their sexual performance.)

The opinion of girls themselves about whether having a baby would negatively influence their chances of finding a good partner was the most important to know, because that would be an important factor in their decision to abort a pregnancy. Most girls in the focus group discussions thought that they would have more problems getting a good marriage partner with a premarital child. They realised that others would question their character and that potential husbands could be restrained by practical problems, such as the biological father claiming the child after he had financially supported it. They know that according to prevailing traditional law, the father has the right to do this. Whereas some of the boys saw the advantage of an already sexually experienced girl, some girls expressed their fear that men would not enjoy sex with them as much, because after delivery they would have a wider vagina and have sagging breasts from breast-feeding their baby.

Girls in the FGDs could see only a few reasons why a man would want to marry a girl with a child already. For a man with infertility problems, marrying a woman with children and adopting them would be a way out of a childless life. Girls had also heard that if a man marries a woman with a child, this might help his other wives to conceive. It might even be written in a man's destiny that he will marry a woman with a child. They also realised that girls with children might have to settle for older men who want to have younger wives, but who cannot afford younger wives without babies because their bridewealth will be too high. Girls in the focus group discussions reasoned that having a baby would show that the character of the baby's mother would not be so bad after all, because she decided *not* to have an abortion. A woman choosing abortion proves she must be immoral and of bad character. The messages of romantic love have taken root in Yoruba society, because girls in FGDs expressed the hope that a desirable man would just fall madly in love with a girl and then would not mind whether she had a child or not.

Pregnancy in school

Community members, old and young, female and male, acknowledged that abortion happens most frequently among secondary schoolgirls and consider it a big problem. All personally knew schoolgirls who had gotten pregnant. Perhaps it was because the community members recognised the magnitude of the problem that they were so willing, almost eager, to talk about abortion among schoolgirls.

Despite their eagerness to discuss the problem, most were quite disparaging about the girls who got abortions. Adults were more disapproving of unwanted pregnancy and abortion by schoolgirls than of abortion among any other group of women. All adult FGD groups considered schoolgirls who got pregnant to have been badly brought up, not serious about their studies, and/or wayward and stubborn. All adults said that the girl should never abort, but have the baby instead. None of the adult groups had any sympathy for a pregnant schoolgirl. They condemned the pregnancy and considered it the girl's own fault that she got pregnant. They said that people gossip about such a girl and would call her 'prostitute' and 'public dog'. The parents should try to find the person responsible for the pregnancy and ask him and his family to take responsibility, which would be the traditional way to solve the problem. If no one would take responsibility, the parents themselves should take care of the baby. Most believed that the girl could go back to school after delivery. Some male community members said the girl could never go back to school, because she obviously found pregnancy more important than her studies, so she should bear the consequences

and take care of her baby. Some fathers were very harsh and said they would just send the girl out of their house to go and join whoever had impregnated her.

The biomedical health staff in both Lagos and Epe and ethnomedical staff in Lagos (but not in Epe) were slightly more lenient in their opinions of abortion by schoolgirls than community members were, although the majority still disapproved of it. They understood the pressure on girls to continue with their education and the only sure way a pregnant girl could continue her studies would be to abort.

In general, the youth in FGDs had more sympathy for schoolgirls getting pregnant than the adults had, but they too condemned abortion. At least the youths tried to understand what had led girls to getting pregnant, and differentiated between girls getting pregnant through their own fault or otherwise. Some girls may be more or less forced to have sex, their situation is different from girls who actively look for it. Adults did not make this differentiation, but considered any pregnancy the fault of the girl. It was striking that none of the adults and boys ever talked about 'the fault of the man who made her pregnant'. The opinions did not differ much between girls and boys in the focus group discussions, although in general, the girls sympathised more with their fellow sex, probably because they could imagine it happening to them as well. Boys would feel sympathy only if the pregnancy were not the girl's fault. If she had herself to blame, the majority of boys condemned her for being foolish, throwing away her future and disappointing her parents. Girls said they would still sympathise with a girl who got pregnant through her own fault, because she would have to go through the trauma of delivery, she would have to face her parents and most probably would have to stop her education.

Youths' opinion about abortion is far less compassionate than their opinion about pregnancy. Most schoolboys and girls in the FGDs and during group work condemned girls who aborted a pregnancy, although they know it happens often, and all of them know of girls who aborted. Such a girl would be called a 'murderer', 'sinner', 'prostitute', 'not serious with her studies', or a 'heartless girl'. However, although they condemned abortion by schoolgirls (and all abortions for that matter), the youth also understood the dilemmas of a pregnant schoolgirl, who might often not have another option. As the boys in one of the FGDs expressed it: 'If she wants to save her head, she just does not have another choice than to abort.' The dilemmas that pregnant girls have to cope with will be explained in detail in Chapter 5.

Radiating a negative opinion: health providers' attitude

Public health staff members are part of the society they originate from, and most of them share society's negative opinions of women who have had an abortion. Staff abuse, mock and reprimand them for their immoral and foolish behaviour. I have unfortunately observed this negative attitude of staff several times during my fieldwork, and many women have complained about it. Of course, not all health-care workers are the same; some are very compassionate. When hospital staff discussed, in working groups, the topic 'staff attitudes towards women having had an abortion performed', they admitted that they normally had a harsh attitude towards women who came to the hospital with complications of induced abortion. They said they were often furious, or at least annoyed with such women. However, after having shown their anger, they would undertake the necessary action to save the life of the woman and give her the necessary treatment. Some said that they show pity on the victim only in the case of rape.

Staff of rural clinics were less adamant. They said that if they react too harshly and use abusive words, they might discourage the woman from going to the general hospital, where she should go for adequate treatment. They accused hospital staff of abusing patients, especially in the case of a young girl, because this would always bring down the girl's morale and even delay her recovery.

Legal status

Most community members and health-care providers, are vaguely aware that abortion is illegal, but do not know about the actual legal technicalities or the conditions under which it is allowed. A 38 year-old Muslim woman who participated in the community survey on Lagos Island, said she did not believe in contraception and abortion, but nonetheless empathised with women who die of abortion. She stated the relationship between illegal and unsafe abortion as follows:

Some people do the abortion and die, some have problems after that; it will lead to operation later. Some even get infected because some of the doctors do not take care of their equipment. Well, that gives the patients problems and it is not all the doctors who have experience. We want the government to see to this instead of people dying of abortion in the hand of the private doctors. It is at the last minute that they take them to the government hospital. If they can handle it, fine, if not they die. So government should legalise this so that people would not be dying unnecessarily and at a high price too.

It was surprising, in view of the generally negative opinion on abortion, that most health professionals and community members involved in participatory sessions, saw the advantage of legalising abortion after they had been informed about the findings of this study. They realised it would decrease the rate of unsafe procedures. The majority of the participants in the staff workshops (both in Epe and Lagos) would like to see the provision of safe legal abortion services at an affordable cost in public hospitals.⁴ They reasoned that in this way, private doctors and other abortionists would no longer be able to make a lucrative business out of performing abortions without any quality or safety controls, at the expense of the health of their clients. Women would stop patronising them if there was a better, safer alternative and when abortion is not such a stigma, i.e. if it were legal. The surprisingly positive attitude of health staff may be attributed to the fact that they often see the problems of complications of induced abortion in their clinics and would therefore be inclined to consider abortion more as a health problem than a moral problem. Yet some ambiguity seems to remain, since they admitted that their attitude towards women with complications had not always been pleasant, because they condemned them on moral grounds.

Prevalence of abortion

The community members involved in FGDs acknowledged that abortions occur often. I have tried to verify the community's idea that 'abortion is very common'. 'Abortion prevalence' in this study is defined as 'the percentage of women who reported ever terminating a pregnancy'. The data collected do give an indication of the high prevalence of induced abortion and in particular of unsafe induced abortion among the sampled populations, who are not atypical of Yoruba women. Besides indicating the magnitude of the problems, the data also make clear that the problems of abortion and unsafe abortion are largest among specific groups of women, i.e. schoolgirls and apprentices.⁵

Abortion in urban and rural areas

The prevalence of induced abortion was calculated based on a total sample of 919 women who were interviewed in the ANC survey and the community survey in Lagos (urban) and Epe (rural).⁶ Table 4.3 relates the abortion prevalence to location and religion.

Table 4.3. Prevalence of abortion among women in the ANC survey and the community survey, by location and religion

study population	Lagos		Epe		all	
	% aborted	N	% aborted	N	% aborted	N
<i>religion</i>						
Muslim	45%	242	17%	266	30%	508
Pentecostal	53%	74	20%	69	37%	143
<i>Aladura</i>	39%	39	17%	98	23%	137
Mission	58%	33	15%	53	31%	86
Roman Catholic	50%	14	14%	14	32%	28
Traditional	57%	7	17%	6	39%	13
All	47%	410	17%	509	30%	919

The figures support the community's perception that abortion is very common. In all, close to one-third (30%) of the 919 women reported having had at least one induced abortion. As was expected, the percentage of Lagos (urban) women with an induced abortion (47%) was significantly higher, nearly by a factor of three, than that of women in Epe (rural), where just 17% reported abortion.⁷ Several factors may explain the large difference in abortion prevalence between Epe and Lagos. There is probably more social control in villages such as Epe than in a city like Lagos. In villages, people know each other and ask about each other's movements. If a fellow villager spots someone at an unusual place or in unusual circumstances, this will surely become known in the village. The social control in rural areas may work to reduce the rate of abortion in two ways; single girls have less opportunity to meet secretly with the other sex, and it may be more difficult to have an abortion without others finding out. The tighter social control in villages also makes it easier for parents to find the person responsible for the pregnancy of their daughter so that they can attempt to force him to marry her. A girl in Epe who gets pregnant may also not consider it a big problem to marry, whereas a student or apprentice in Lagos would want to continue her education without the disturbance of a pregnancy or marriage. Lower prevalence figures for abortion may also be due to the fewer abortion providers available in Epe compared to Lagos (which will be discussed in Chapter 5).

In informal interviews, informants often stated that those belonging to other religions than their own abort more frequently. These statements were not supported by the study findings. Although women of some religions, i.e. Traditional (39%) and Pentecostal (37%) seem to abort more compared to those belonging to other religions, i.e. *Aladura* (23%) and Moslem (30%), the differences are small and not significant. In a previous section, it was discussed how a relatively high percentage of *Aladura* respondents, compared to other

religions, were positive about abortion. The findings thus suggest that a positive opinion does not mean that those women abort more often, as is commonly assumed.

Calculating the abortion ratio, the percentage of the total number of pregnancies the respondents had that were aborted, indicates that in Lagos, more than one-fifth of all pregnancies ended in abortion; in Epe this figure was 6%.⁸ Abortion can therefore technically be considered as factor lowering the overall fertility of women in Lagos. However, I doubt whether individual women consider abortion as a deliberate method to regulate their personal fertility. In Chapters 5 and 6 it will become clear that most women resort to abortion for other reasons than of regulating fertility.

The incidence of abortion, defined as the percentage of women who had an abortion in the year preceding the survey, was 7%. This figure is based on the findings of the community survey only and not the ANC survey. It is unsurprising that only one woman in the ANC survey (who were, by definition, pregnant) sought an abortion in the year preceding the survey. Three of the 41 women in the community survey who aborted in that year had had two abortions.

Background of women aborting

Knowing the percentage of women who aborted gives important information about the magnitude of the problem, but it does not tell us much else. We need to know which groups of women abort to be able to identify the groups at risk. If religion does not appear to influence the risk of abortion, who are the groups at risk, besides the women in urban areas? Only the incidence of abortion among different groups of women in the community survey in the last year could indicate which groups presently abort more than others. However, with the study data at hand, we cannot arrive at conclusions because figures are too small. Although we have a sample of 69 women who aborted in the year preceding the interviews, only 41 were women from the community survey who would be representative of Yoruba women.⁹

In order to get an impression of which groups most frequently aborted, Table 4.4 presents the social characteristics of the 652 women who reported abortion experiences, at the time of their first and subsequent abortion. The 652 women reported a total of 1073 past abortion experiences. The number of abortions reported per woman ranged from one to nine, with a mean of 1.6. More than two-fifths (44%) had more than one abortion, 31% had two, 10% had three, 2% had four and the remaining 2% had five or more. The experiences date back to 1973, but most abortions (68%) were carried out from the year 1991 onwards.

Only 10% were performed between 1973 and 1985 and 22% between 1986 and 1990. The table also compares the women's characteristics at the time of the abortion(s), to those at the time of the interview.

Table 4.4. Social characteristics of women who aborted, at time of their abortion (first, subsequent and all experiences) and at time of the interview

characteristic	at time of abortion			at time of interview (N=652)
	1 st experience (N=652)	subsequent experience (N= 421)	all experiences (N=1073)	
<i>age group</i>				
Below 20*	34%	14%	26%	2%
20-24	42%	45%	43%	19%
25-29	17%	28%	22%	44%
30-34	4%	8%	6%	23%
35 and over	2%	6%	4%	13%
Total**	100%	100%	100%	100%
<i>marital status</i>				
Single	79%	74%	77%	16%
Married	21%	24%	22%	83%
Separated/divorced/widowed	1%	3%	2%	1%
Total**	100%	100%	100%	100%
<i>schooling status</i>				
Secondary/primary student***	26%	10%	20%	
University student	15%	19%	16%	}7%
Apprentice	15%	12%	14%	
Not in school	44%	60%	50%	93%
Total**	100%	100%	100%	100%

* The majority fell in the age group 15-19, just 2% of all experiences were of girls below 15 years, 3% of first experiences, and at the time of the interview no girl was below 15.

** Figures may not add up to 100% due to rounding

*** Two girls were primary school students

Table 4.4 shows that the social characteristics of women at the time of their abortions differed significantly from their characteristics during the interview, which proves the importance of asking about those characteristics retrospectively. If one would use present background characteristics (Table 4.4, last column) to describe the women who are aborting, one gets a completely different and erroneous profile of a stereotypical woman who aborts: a married woman, around 28 years old, who is not in school or in apprenticeship. However, the average woman who aborts is a young, single woman who is receiving some type of education.

The ages of the women at the time they induced abortion ranged from 12 to 42, with a mean age of 22.7 years for all experiences. For the first experience the ages ranged from 12 to 41 years with a mean age of 21.7 years. The mean age for subsequent experiences was slightly higher with 24.3 years. Overall, about half of all abortions were performed on young women, either in school (secondary or university) or in an apprenticeship. For the first abortion only, the percentage who were getting an education, amounted to 56%. More than two-thirds of all reported abortions took place in women under 25 years of age, and a quarter of all abortions were in the under-20 age group. If we focus only on the first abortion experiences, an even higher percentage of women are in the younger age groups; about three-quarters of women had their first abortion when they were younger than 25, and about one-third was younger than 20. Most of the women in the younger age categories were in school or apprenticed; 80% of under-20 were in school and 55% of the 20 to 24 year-old women were.

Some 77% of all women who aborted were single and this was about the same for the first abortion and all abortions. At the time of the interview, only 16% were single. That abortion mainly occurs among single women is proved by the high prevalence of abortion among the women who were single (and never married) at the time of the interview. In Lagos, 72% of the 53 interviewed single women in the community survey reported abortion, while in Epe this was lower, although still 10 of the 17 interviewed single women (59%) in Epe had had an abortion.¹⁰

Proportion of unsafe abortions

Even knowing that young, single women who are still following some type of schooling abort more than married women, does not give the whole story. Abortion does not have to be problematic and life threatening. As indicated in Chapter 1, an abortion performed under hygienic conditions by a qualified and experienced person, in the first trimester carries very few health risks. The dangers are when women have *unsafe* abortions.

In this study, the safety of the abortion methods that women used could not be examined; we did not observe abortion procedures. However, an indication of the relative safety of the abortions women had was made by evaluating both the methods and providers women said to have used and the timing of the abortion. The following criteria for safe and unsafe abortions were applied in this study:

- *Safe* would be an abortion in the first trimester in a private or public hospital by dilatation and curettage (D&C) or vacuum aspiration (VA), without any preceding attempt at self-induced abortion.¹¹

- *Unsafe* would be all other abortions: 1) an abortion not performed in a private or public hospital; 2) an abortion method other than D&C or VA; 3) an abortion after the first trimester; 4) an abortion where the woman tried a self-induced abortion first before going to a hospital.¹²

I realise that the criteria used cannot differentiate fully between safe and unsafe abortions. The quality of private hospitals differs considerably as was indicated in Chapter 3. As such, first trimester abortions by D&C or VA in private hospitals can be unsafe, when performed by an unqualified or unskilled provider, or under unhygienic conditions.

When applying the criteria to the 1073 abortion experiences of the 652 women, more than one-third (37%) of their abortions are labelled as unsafe. Table 4.5 clearly indicates that some groups of women had more unsafe abortions than other groups.

Table 4.5. Safety of reported abortions, by women's background characteristics

<i>background</i>	<i>% unsafe abortion</i>	<i>% safe abortion</i>	<i>N (=100%)</i>
<i>age group</i> ^{xx}			
Below 20	47%	53%	276
20-24	38%	62%	465
25-29	28%	72%	232
30-34	35%	65%	60
35 and over	18%	82%	39
<i>schooling status</i> ^{xx}			
Primary/secondary student	51%	49%	213
University student	25%	75%	175
Apprentice	45%	55%	149
Not in school	34%	66%	535
<i>marital status</i> ^x			
Single/engaged	40%	60%	823
Married	30%	70%	233
Divorced/separated/widowed	6*	11*	17
<i>All</i>	<i>37%</i>	<i>63%</i>	<i>1073</i>

* Because total N of divorced/separated/widowed women is only 17, numbers are given and not percentages

^{xx} Chi-square test is significant at $p < 0.01$

^x Chi-square test is significant at $p = 0.03$

Table 4.5 shows that girls under 20 had a significantly higher percentage of unsafe abortions than older women had. It appears that secondary schoolgirls in particular, the majority of whom fall in the age group of below 20, tend to resort to unsafe methods for abortion (51%). Apprentices are also a group at risk; 45% have had unsafe abortions. It was striking that the proportions of unsafe

abortions for first (39%¹³) and all abortion experiences (37%) did not differ much. This could indicate that these girls and women might have been aware of which methods to use, but had reasons for having unsafe abortions anyway, even if they knew the risks involved. The reasons why women, and in particular schoolgirls and young women, might resort more often to unsafe methods of abortion will be explained by the case histories in Chapters 5 and 6.

The real figures for unsafe abortions are probably even higher than presented in Table 4.5, because the criteria for safe abortions should be stricter. The 41 in-depth interviews with women who came to the hospital with complications of induced abortion provided more detailed information on the abortion providers used than we were able to obtain in the semi-structured interviews with the 652 women. From these in-depth interviews, it became clear that most private hospitals and clinics they went to for treatment were unsafe, as indicated by the low price of the procedure, which is a proxy for poor conditions of service. Abortion in a good private hospital in the first trimester would cost at least 1,500 naira (at that time about 16 US dollars). Some women paid as little as 500 naira for a D&C in a private hospital. The only safe abortion a woman can get for that low of a price would be a manual vacuum aspiration (MVA) in a public or university hospital.¹⁴

Another reason why the real figures on unsafe abortion, are higher than presented here is that we only recorded the abortions of women who survived abortion; we missed the cases of women who died. From the 106 histories I collected about women who died of abortion, we can deduce that 95% of these abortions were unsafe according to the study's criteria for safe and unsafe abortion.

Abortion complications and deaths

Thirteen percent (13%) of the 1073 reported abortion experiences of the 652 women resulted in moderately serious complications, including bleeding, abdominal pain and irregular menses. Some had more serious complications, including pelvic inflammatory disease, ruptured uterus and septicaemia.

Abortions more often lead to complications when performed in an advanced stage of pregnancy and with unsafe methods. The figures of the 1073 abortion experiences show that, when performed at one or two months, only about one-tenth of abortions resulted in complications, while at four months and over, almost two-fifths (39%) of the women reported them.¹⁵ Figures on complications clearly show that having an abortion in a private hospital is generally safer than abortions performed by other providers. Less than one-tenth (9%) of abortions performed in private clinics (by D&C or VA) were reported to

end in complications, compared to more than one-quarter of abortions performed by other providers.¹⁶ The highest percentage of complications occurred after self-abortion by oral use of drugs or other substances (26%) and by a provider giving injections (27%). When combining the conditions of the abortion (timing, providers and method) by applying the criteria as explained in the previous section, we found that 24% of relatively unsafe abortions resulted in complications, whereas only 7% of relatively safe abortions did so.¹⁷ The presented figures cannot be interpreted to indicate that 'only' 13% of abortions end in complications, because the sampled experiences are not representative of all abortion experiences. As mentioned in the last section, they do not include at least one important category, i.e. those women who suffered the ultimate complication of abortion: death.

The abortion mortality in Nigeria can only be estimated, because no community-based studies exist. One can infer that the rate is probably high from hospital-based reports indicating that 35% or more of maternal deaths in Nigeria are due to induced abortion (Okonofua et al.1992:75; Royston & Armstrong 1989:110). However, as indicated in Chapter 1, these reports are not reliable indicators. Abortion mortality statistics as calculated from official hospital statistics will be an underestimation of the real figure. First, not all abortion deaths in public and private hospitals will be recorded as such, especially if it was a death after an illegal abortion performed in the hospital (thus not a treatment of abortion complications, or abortion on health grounds). Also, women who die of abortion at other providers' places (e.g. back-street abortionists, chemists or traditional healers) will not likely be counted in the governmental statistics. Additionally, the present study discovered that about one-quarter of the women who died of abortion (as recorded in histories told by community women) died at home, while 6% died on the way to the hospital. These abortion deaths most probably will also not appear in the statistics, because relatives will not willingly make public the fact that their daughter or wife died of abortion. They will report another cause of death instead.

The present study cannot measure the magnitude of the problem of abortion deaths, but the fact that more than one-quarter (28%) of 377 women in the community survey had personally known women who had died of abortion is an indication of the magnitude.¹⁸ The women who died were their neighbours, friends, classmates, co-apprentices or relatives. Their histories also can give an indication of the groups most vulnerable to die from abortion or abortion-related complications. The figures in Table 4.6 compare the background characteristics of women who survived abortion (respondents of the abortion questionnaire) and those who died from abortion.

Table 4.6. Background characteristics of women who survived abortion and of women who died from abortion.

<i>characteristic</i>	<i>women who survived abortion (N=1073)</i>	<i>women who died from abortion (N=106)</i>
<i>age</i>		
Age below 20 years	26%	52%
Age 20 years and above	74%	48%
<i>Total</i>	<i>100%</i>	<i>100%</i>
<i>schooling status</i>		
Student primary or secondary school	20%	47%
University student	16%	3%
Apprentice	14%	18%
Not schooling or apprenticed	50%	32%
<i>Total</i>	<i>100%</i>	<i>100%</i>
<i>marital status</i>		
Single	77%	75%
Married	22%	23%
Separated/divorced/widowed	2%	3%
<i>Total</i>	<i>100%</i>	<i>100%</i>

Source: 1) women recounting 1073 personal abortion experiences, 2) women in community survey recounting 106 histories of death from abortion.

Table 4.6 makes it blatantly clear that secondary schoolgirls are at the highest risk of dying from abortion; 47% of the histories of women who died from abortion concern secondary schoolgirls. The data have to be treated with some caution though, because not all abortion deaths may be publicly known as such. Especially married women who actually died from abortion related causes, may be said to have died naturally of a pregnancy-related or other cause. However, the differences for age and schooling status between those women surviving and those dying from abortion are large enough to conclude that primary and secondary schoolgirls and girls under 20 years of age are at the highest risk of death resulting from abortion. University students are relatively less represented among women who died. They might have safer abortions compared to other groups. Figures from the personal abortion experiences as presented in Table 4.5, support this. Among schoolgirls, 51% of abortions were unsafe, against 'only' 25% of abortions of university students.

Conclusion

All groups in Yoruba society seem to share in the dominant discourse that condemns abortion: younger and older women, men, boys, girls, women who had an abortion, women who did not have an abortion, biomedical and ethnomedical service providers. Although they proved to be fully aware of the different circumstances that make pregnancies unwanted, including financial problems, pre- and extramarital affairs and too short of a birth interval, they would hardly ever judge aborting these unwanted pregnancies positively. The only exception is when the pregnancy is obviously not the woman's fault as in the case of rape, and in particular if the person who raped the woman is not known or cannot be held responsible. Not only societal rules and the law condemn abortion as immoral and against the will of God, different religions do as well. However, the study findings suggest that a shift is taking place in reasons why persons think negatively about abortion. Presently, the main objection against abortion seems to be that it is extremely risky for the health of the woman. This concern is not surprising given the reality of the high incidence of abortion and abortion complications that increasingly surface.

The pertaining dominant rules opposing abortion do not prevent abortions from being a common occurrence, as community members acknowledged. The abortion prevalence determined in this study is among the highest found in any study done among Yoruba. In urban areas, almost half of the interviewed women in the community survey reported to have had one or more abortions, while in rural areas close to one-fifth had one or more abortions. These high figures may be partly due to the 'sensitive' study methodologies used, i.e. the highly capable interviewers and the design of the data collection tools as explained in Chapter 2. Another reason for the relatively high figures might very well be that the abortion incidence has been increasing over the years. Some studies cited in Chapter 1 date back to the 1970s (although also the recent study of Henshaw et al. 1998 gave an annual abortion rate, thus incidence, of 'just' 4.6 per 100 women whereas this study found 6.7). Older women and traditional birth attendants involved in this study always pointed out that abortion did not happen in old times, or that it at least happened far less frequently than it does nowadays. Asking them how it is then possible that they know traditional methods of abortion, the TBAs responded that the methods for abortion are about the same as those for bringing about missed menstruation (for other reasons than pregnancy) and for 'washing' the uterus after miscarriage or delivery.¹⁹

The high incidence of abortion does not necessarily have to pose a health problem. The real problem is that so many abortions are performed under unsafe conditions and thus carry a high health risk. Women have late abortions,

after the first trimester of pregnancy, and often end up with providers who use unsafe methods, or try to abort themselves. The figures presented in this chapter show that the most vulnerable groups are young single girls under 20 years of age, and, in particular, secondary schoolgirls and apprentices. Many abortions occur in these groups and they have more unsafe abortions often leading to complications and death. Having a girl dying of abortion in the family is a reason for shame, as informants told me. If neighbours learn what happened, they would start gossiping about who is to blame for the misfortune. Usually the parents are blamed for not being able to 'control' their daughter, and the father will blame the mother. A sister may be suspected of possibly following the example of her sister who died supposedly as a consequence of 'immoral' and 'foolish' behaviour.

In Chapters 5 and 6 we will look beyond the figures and try to understand *why* so many women abort, violating the societal rules, and why they often resort to unsafe and risky abortion methods.

