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### Secret strategies: Women and abortion in Yoruba society, Nigeria

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## PREVENTING UNWANTED PREGNANCY

The abortion experiences presented in Chapters 5 and 6 revealed that most women do not consider abortion as a preferred form of birth control, but rather as an emergency method to solve the problem of having an unwanted pregnancy. While reading these experiences, readers must often have asked themselves, 'Why did these women not use contraception if they did not want to get pregnant and fear abortion?' or 'Why did they use such ineffective methods of contraception?' In the conclusion of this chapter, I will explore the following five 'hypotheses' that could shed light on these questions:

1. Contraceptive services and devices are not available;
2. Sociocultural norms deter women from using contraception;
3. Contraceptive services that are available are not accessible or acceptable;
4. Women do not know (enough) about modern contraception;
5. Contraceptive failure is high, because methods used are not effective or wrongly applied.

### *Sources of information*

The quantitative information mainly originates from the semi-structured interviews with women in the ANC survey, the community survey, the infertility survey and interviews with women who had an abortion in which women reported on their experiences with unwanted pregnancies and their current and/or past contraceptive use. Qualitative data was mainly provided by focus group discussions with community groups, in-depth interviews with 41 women who came to the hospital with complications of abortion, stories on abortion written by secondary school students, exploratory interviews and group sessions with secondary school students, traditional midwives and biomedical health staff. This qualitative information concerns traditional and present-day rules for childbearing, motivations for use or non-use of specific contraceptives, knowledge and opinions on contraception and views on premarital sexual activity (Table 7.1).

Table 7.1. Study populations and sample size for Chapter 7: Preventing unwanted pregnancy

<i>study populations</i>	<i>sample size</i>
Women in the community survey	652*; 283 in Lagos, 369 in Epe
Women in the ANC survey	367; 179 in Lagos, 188 in Epe
Women in the infertility survey	69; 36 in Lagos, 33 in Epe
Women with abortion experience(s)	652*; with 1073 aborted experiences, 823 of single women, 233 of married, 17 of divorced/widowed
Women with complications from abortion	41
Elderly women, women, men, boys and girls in the community	5 focus group discussions with each adult group, 7 with each youth group
Secondary school youth	7 group discussions, 106 written stories
Biomedical service providers	2 group discussions, 46 self-administered questionnaires
Traditional birth attendants	42 in-depth interviews, 6 group discussions

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

### *Prevalence of unwanted pregnancy*

Experience with unwanted pregnancy was common among women involved in this study.<sup>1</sup> More than two-fifths of the women (45%) in the community survey and ANC survey said they had one or more unwanted pregnancies in their lives; of all pregnancies the women in the two surveys reported to have had, one-fifth was unwanted (Table 7.2).

Table 7.2. Experience with unwanted pregnancy of women in the ANC and community survey (combined), by location

<i>study population /location</i>	<i>unwanted pregnancy</i>	<i>N</i>
<i>women</i>		
Epe	31%	509
Lagos	62%	410
All	45%	919
<i>pregnancies</i>		
Epe	12%	1745
Lagos	29%	1383
All	20%	3128

Twice as many women in Lagos (urban) as in Epe (rural) reported having experienced unwanted pregnancies. This difference becomes even more pronounced when considering the total number of unwanted pregnancies reported by the women in the surveys; two-and-a half times as many pregnancies were

unwanted in Lagos than in Epe. The differences are not surprising. Girls in rural areas marry earlier than those in urban areas do, and are therefore not so much exposed to the risks of getting pregnant (without wanting to) before marriage.<sup>2</sup> Moreover, married women in rural areas are less used to questioning the desirability of a new pregnancy, as women in towns do, and sooner accept it. In addition, these figures *could* indicate that women in Epe prevent unwanted pregnancies by using effective contraception. The validity of this supposition will be explored later in this chapter.

The majority of unwanted pregnancies occurred among single women. Of the total of 619 unwanted pregnancies recorded in the ANC and community surveys, only 31% were reported by married women, while 69% were reported by single women. When separating the single women according to schooling status, secondary schoolgirls emerge as the group most vulnerable to unwanted pregnancies; with 34% of the unwanted pregnancies, these schoolgirls represent a large proportion of all unwanted pregnancies of single women.<sup>3</sup>

A high prevalence of unwanted pregnancy is an indication of non-use of contraception, incorrect use of it or use of ineffective contraception.

### *Definition of contraception*

The definition of 'contraception' for this anthropological study encompassed more than is usual in demographic surveys and other studies on contraception. The latter mainly consider modern contraceptives and sometimes include natural or traditional methods such as withdrawal and periodic abstinence. In contrast, our definition of contraceptives included 'all methods and measures which sexually active women and men report using before or after intercourse, which are intended to prevent pregnancies'. Thus, for this study, the intention of the method is more important than the effectiveness and post-coital contraceptive methods are included.<sup>4</sup> By this definition, premarital abstinence by a girl or young woman who is still a virgin did not fall within the study definition of contraception, while postpartum abstinence did. Within this broad definition, women reported a large variety of methods and measures they used to prevent pregnancy, which I classified into five functional categories, according to their (biomedical) effectiveness, possible danger to health and involvement of a service provider (Table 7.3).

Table 7.3. Categorisation of contraceptive methods used in the present study

<i>contraceptive category</i>	<i>contraceptive methods</i>	<i>comments</i>
Modern (biomedical) methods indicated for contraception	Oral contraceptive pills (OCP), intra-uterine contraceptive device (IUCD), injectables, condom, tubal ligation, spermicides, diaphragm, Postinor (an emergency contraceptive pill)	Most of them are effective when correctly used, with various side-effects. Some are provider dependent and others can be bought without prescription.
Natural methods	Periodic abstinence ('safe period' or 'rhythm method'), breast-feeding, postpartum abstinence, withdrawal	These may not be very effective, but do not have adverse side-effects. No provider is needed (though sometimes the provider explained the method).
Traditional methods	<i>Oruka</i> (ring), <i>aseje</i> (concoction), <i>igbadi</i> (waistband), <i>ileke</i> (beads around the waist), <i>agbo</i> (herbal drink)	The effectiveness is not scientifically proven; they have few known health risks. They are provided by TBAs, traditional healers and herbalists.
Modern drugs that are not indicated as contraceptive and substances	Menstrogen, Andrew's Liver Salt, Alabukun, Apion and Steel, Ampiclox, Ampicillin, Tetracycline, Codeine and potash (the most common)	These methods are ineffective and/or dangerous because of adverse side-effects. They can be bought without a doctor's prescription.
Home methods	Drinking of salt water, lime, Schweppes, Krest bitter lemon, or gin; vaginal douching with any substance; urinating immediately after intercourse	They are rather ineffective, with little adverse side-effects, unless used in excessive dosage. No provider is needed.

### Contraceptive services

Contraceptive devices are widely obtainable from several outlets, and are especially available in urban areas. Public hospitals and health centres usually have separate family planning (FP) clinics that provide information, counselling and (modern) devices including oral contraceptive pills (OCP), IUCDs, injectable contraceptives, condoms and spermicides; some also may offer sterilisation services. The suppliers for public FP clinics are the Federal and State Ministries of Health who receive FP products for free or buy them from international organisations, such as UNFPA and the International Planned Parenthood Federation (IPPF), at a reduced price. Non-governmental organisations (NGO) such as the Planned Parenthood Federation of Nigeria (PPFN) do run FP clinics in which all services, including counselling, are available.

In addition to the many public clinics, there are many sources of contraceptive products in the private sector. Private hospitals do not have special FP clinics, but some may provide contraceptive methods. Pharmacies, chemist shops and drugs peddlers also provide modern contraceptive methods, but without giving their clients much counselling or information about them. These providers may also sell patent medicines as contraceptives that are not meant (indicated) for contraception but may work as such (see Table 7.3). Non-public institutions buy their supply through the wholesale market. A program that promotes the active social marketing of contraceptives is run by a Nigerian NGO, the Society for Family Health (SFH), which distributes condoms and other modern contraceptives to warehouses throughout Nigeria.<sup>5</sup> From there, these products reach wholesalers, pharmacies, chemist shops, patent medicine stores and private FP clinics. In addition to SFH, many private traders import contraceptives from all over the world.

Prices of modern contraceptives can vary, and usually depend on where one buys the methods. The prices of the same product at public FP clinics are usually the cheapest, chemist shops and drugs peddlers are more expensive, and private clinics and pharmacies are the most expensive. In 1997, the time of the present study, the cheapest condoms in a 4-pack were 10 naira (about 0.10 US dollars). The cheapest cycle of OCP cost as little as 5 naira in public FP clinics, while a new client in a public clinic had to pay 30 naira for the booking card, examination and one cycle of pills. An IUCD insertion pack (including the IUCD, anti-bacterial soap, gloves and swabs cost 100 naira, injectables 60 naira, and a 'sterilisation pack' (for tubal ligation) 1,500 naira.

Whereas modern contraceptives are widely available and likewise affordable for most people, they are not easily *accessible* to all, especially to girls and young single women. The policy, although unofficial, in public FP clinics is to not provide contraceptives to girls in school uniforms and girls obviously still in school, unless they are with their mother. The FP co-ordinator of Lagos Island LGA (one of the study locations) explained, 'It would be really telling them that you agree with them having intercourse and being promiscuous when you supply them with contraception'. I explained earlier in this book that there is generally very little communication on sexuality between Yoruba parents and their children, so not many girls would involve their mother if they wanted to use contraception. The 1996-1998 records of the LIMH FP clinic (one of the locations for the present study) illustrate that girls and young women do not get contraceptives from public clinics. These figures indicate that just 2% of the women for whom they provided contraception were below 20 years of age and just 10% were between 20 and 24 years of age. It was therefore no surprise to find that nearly

all the single women in the community survey who were using modern contraceptives reported they had bought them from the chemist shop.

For one reason or another, public FP services do not seem to be accessible to married women either. Figures from the present study on the use of contraceptive providers illustrate that public FP clinics play a minor role in provision of oral contraceptive pills (OCP) and condoms, and not only to single women, but to married women as well. Most of the women interviewed for the community survey who used OCP bought these pills in a chemist's shop, where they can be bought over the counter. The same applies to condoms. Women usually go to a public FP clinic only for IUCD and injectables, because these methods require medical examination and trained personnel to administer them. This corroborates with Lacey et al.'s national Nigerian study in 1991-2 (1997:165) in which they found the same trend. Very few women in the present study bought contraceptives from private clinics, probably because these private clinics rarely provide contraceptive services. Private practitioners explained that providing FP is not a profitable business.<sup>6</sup> There was one exception, a private clinic in Epe where many women, even schoolgirls, got injectable contraceptives. Clearly the owner of this clinic saw profit to be made in this business that obviously met a need.

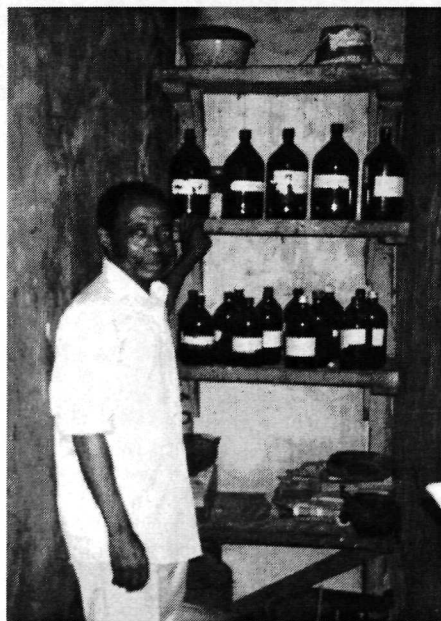
### *Traditional contraceptives*

Traditional healers, including traditional birth attendants (TBAs) and herbalists, provide women and men with several traditional contraceptive methods, some to be used before, and others after, intercourse. 'Traditional methods' may not be traditional in the sense that they were often used in former days. Traditional healers have adjusted to the trend of family planning, by re-labelling methods they formerly used mainly for *juju* to cause infertility and miscarriage, as contraceptive.<sup>7</sup> TBAs explained that most methods are to be used by the woman, but some by the couple. There are no standard traditional contraceptives; each TBA has his or her own concoctions, formulas and incantations. There are, however, different *types* of contraceptives that are explained in this section, beginning with the most commonly used.

*Oruka* is a charmed ring usually made of copper, which a woman wears around her finger. Some TBAs advise their clients to always wear it, except when they are menstruating, because the menstruation blood will spoil the 'medicine' of the ring and it will lose its potency. Other TBAs said their *oruka* should be put on before intercourse and removed after intercourse. Many rings for contraception have taboos attached, and these taboos differ by TBA. When using the *oruka*, the TBA may tell the woman she is not allowed to eat certain foods or drink certain drinks, not to share an egg with someone, not to touch a corpse or



Traditional bowls with *aseje*



Chairman of Lagos Island TBA association, with bottles of *agbo*



*Oruka* and seeds of the *wurapa* tree

that the ring should not touch the ground.<sup>8</sup> If the taboo is violated, the ring will lose its potency and the woman may get pregnant. TBAs in Lagos said there are two different types of *oruka*: *oruka baaba*, brownish-red in colour, and *oruka onirin*, silver-colour. There is no difference between them, apart from their colour. Some women do not like the silver type because people associate it with charm, unlike the brownish red type. Some women, especially Christian women, even prefer to have other rings such as wedding rings and fashion rings be prepared as *oruka*.

*Aseje* is a cooked soup prepared with a variety of ingredients over which incantations are recited. Common ingredients are papaya and tortoise. Only a few *aseje* have a taboo attached to them; with some *aseje* a woman is not to eat certain foods, or not to touch a dead body.<sup>9</sup> Most *aseje* contraceptives are said to be effective in the long-term. They can be reversed with another *aseje*, the recipe for which only the TBA who provided the first one knows. That is why using *aseje* as a contraceptive is considered dangerous. If something happens to the TBA who knows the reverse *aseje*, the woman will not be able to conceive for the rest of her life. In Epe, some of the TBAs said they only prepare *aseje* for women who want to stop childbearing for good, and only with the consent of their husband. Some also let their assistant know the secret of how to reverse it, in case they die and the client wants to reverse it. The TBAs in Lagos said they have *aseje* that are effective for different periods of time, e.g. one month, two months, nine months, but they also have *aseje* that are permanent.

*Gbere* are scarification marks made on the body with a knife or razorblade. The TBA puts medicine into the open cuts and recites incantations. The *gbere* for contraception are usually made at the back of the woman's knee, thigh or lower abdomen. The method is reversible.

*Igbadi* is a charmed waistband or armband that a woman wears. Some must be permanently worn while others must be removed during menstruation. Some TBAs give *igbadi* that have a taboo associated with them. Those mentioned include that the *igbadi* must not touch the ground or that the woman wearing it should not eat crab or share an egg.

*Agbo* is a medicinal cold 'tea', made by soaking and boiling of certain herbs, leaves, and roots. Some of the TBAs said they instruct the woman to drink the *agbo* before intercourse, some after intercourse. As soon as she stops drinking it, she will be able to become pregnant. The seeds from the *wurapa* tree can be swallowed by the woman and is believed to prevent pregnancy for up to five years. Some less mentioned traditional methods of contraception were *ebu*, a powder that should be licked or put in pap, *ileke*, beads worn around the waist, *alasoke*, a charm to be hung in the room and *olose*, black soap with medicine which should be used twice monthly unfaillingly.

TBAs are reluctant to provide schoolgirls with contraceptives, unless the girls come with their mother. In interviews they said that these girls are supposed to concentrate on their studies. However, they were slightly more willing to supply contraceptives to girls in post-secondary education, despite their single status, because these girls are more mature and know what is good and bad for them better than secondary schoolgirls do. TBAs considered only specific contraceptives appropriate for single women, such as *oruka* or *igbadi*, because these would not impair their future fertility. Some other traditional methods, such as *aseje* or swallowing the seed of the *wurapa* tree, have a long period of effectiveness of at least two or three years, and are only deemed appropriate for women who already have many children

### **Ideal childbearing**

Traditional rules about child bearing are still influential, as FGD participants explained. Most Yoruba still disapprove of premarital pregnancy and illegitimate children, with only a few exceptions.<sup>10</sup> Yoruba gossip focuses on childless women as well as on women who have their children too close together. Only the traditional rules about having as many children as possible until menopause is changing somewhat, due mainly to the pressure of economic problems.

Marriages are contracted in order to produce children and childless marriages are considered useless. Delay of pregnancy leads to the suspicion that there is something wrong with the woman. According to traditional Yoruba custom, women should start bearing children as soon as possible *after* marriage. The best age for a woman to marry and start having children was cited as between 20 and 25 years old, according to the older participants in FGDs. They said that by this time, women's bodies would be strong enough to carry the strain of pregnancy and delivery, and complications resulting from a narrow pelvis or immature womb would arise less frequently. At this age, women were also considered mentally ready to meet the responsibilities of parenthood. The younger women in FGDs added another reason for the appropriateness of this age: Women would have completed their education or apprenticeship and probably would have secured regular income from a job or have set up a profitable business of their own.

Another traditional rule of childbearing is to have sufficient time between successive births. According to all older women and the majority of the younger women in the FGDs, the ideal interval between children was three years (as is common in other sub-Saharan societies). This period would give ample time to the mother to recuperate physically and mentally after delivery before becom-

ing pregnant again. The child would have been well breast-fed, and would thus be stronger. It was feared that a new baby would not only take the breast milk from the preceding child, but also take up the mother's necessary care and attention. Participants also pointed to the practical advantages of a three-year interval. The first child would be less dependent on the mother and would even be able to run little errands for her when she was nursing the next child. An interval between children of more than three years was considered disadvantageous because it might lead to disease of the mother and infertility as a consequence of ethnically acknowledged gynaecological problems like *aran giniṣa* (worm in the uterus) and *iju* (fibroid in the uterus). Such problems do not have time to develop when a woman has children with shorter intervals (see Chapter 8).

Traditionally, childbearing should not be stopped intentionally, but should only end naturally when a woman approaches menopause. Older women in the FGDs gave various reasons why ceasing to bear children would be unhealthy. It would be waste of blood for a woman to be menstruating every month without getting pregnant. This condition could lead to illness, because the blood that is wasted is not 'converted' to children." In addition to health reasons, they felt it was wrong to stop because women would not finish all the children 'designated' to them by God and therefore interfere with fate. Yoruba believe in predestination, and one never knows what great future a child whose birth was prevented might have had.

Yoruba still value having many children, but more women and their husbands nowadays want to decide on the number of children for themselves, and not leave it to nature and God. Most FGDs participants said they preferred to limit the number of children to between four and six. In this way, the parents could afford to give their children a better education and care. In addition to economic reasons, participants pointed out that by limiting the number of children, the mother's health would be enhanced, as the woman would be able to properly 'rest' her womb. After the sixth child, it is now considered risky to bear another one. Some older women, however, said that these days, women are not able to bear many children, unlike in their own childbearing days when women were strong. All participants agreed that couples should not have less than four children, because one never knows how many children will survive to bury the parents.

The groups were divided in their opinions about women who are already a grandmother bearing children. A few younger women and all of the older women did not see anything wrong with a grandmother who continued to bear children, whereas some men and most of the younger women in the FGDs were of the opposite opinion. According to the older women, in the past it was not frowned upon, unlike now, when it is considered shameful and people gossip

about and even abuse the pregnant grandmother. They attributed the reason for this change to the economic situation of the country. Many women are pushed harder to finance the family and there is less cheap childcare because couples do not live in extended families in towns. Men and younger women said that it is traditionally one of the grandmother's primary duties to take care of her grandchildren and thus she should stop bearing children herself.<sup>12</sup> A 40-year-old female schoolteacher commented, 'People would abuse her and say that she wants to have the children which her own children are supposed to have'.

#### **Box 7.1. Grandmother pregnancy**

I came across the view that grandmothers should not bear children early in the research, in an exploratory interview with Shade, a 26-year-old married woman with two children, who told me: "It is not good when a woman conceives when her own children have children or are married. Still it happens quite often. My own mother also got a child when I already had two children. I did not like it at all when I heard she was pregnant, because all her attention would be going to her new baby. I had wanted my mother to abort the child, but the people in the church advised my mother not to abort. In fact, this is the reason that I do not see my mother often." At that time I did not ask Shade to explain more about why she was so against her mother, who was in her early forties, having a baby. I was just surprised about her reaction, and was on the side of her mother who was still young enough to have children if she wanted to. I would now explain Shade's attitude in two ways. She felt embarrassed about her mother's baby, as it was a sign of an active sex life, something children do not like to associate with their parents. Secondly she feared her mother would not have time to take care of her grandchildren anymore as she was used to, and this would affect her (Shade's) freedom to do business.

Concerning the age a man should stop procreating, the majority of both male and female participants in the FGDs were of the opinion that there is no age limit. A man can go on having children as long as he is healthy and virile, irrespective of his age. However, some men and women stated that a man should stop having children when he is 50 or 60, either for economic reasons or to protect his health. They believed that prolonged sexual intercourse would weaken a man and shorten his life.

#### **Dominant rules about abstinence**

Premarital abstinence is an ideal that still prevails in Yoruba society. However, all FGD participants believed that premarital sexual relationships are common nowadays. The frequency of such relationships could not be indicated, because girls know that society disapproves of such relationships and therefore keep

them secret. Although they know many youth are involved, parents usually believe their own children are exceptional; their own daughters would not break the taboo on premarital sex.

FGD participants identified several societal factors that could be responsible for the increased frequency of premarital sex. They believed that many parents are so busy making ends meet that they have no time to properly educate their children; these children go astray at the slightest opportunity. The poor economy also makes some families unable to send their daughters to school. They then engage in other activities, including attaching themselves to men of means. These days, the market is flooded with flashy items like watches, earrings, bracelets, trendy clothes and shoes; girls get carried away when men use these to entice them. Girls may also be under influence of peers who encourage them to engage in 'bad' behaviour. Older women in FGDs believed that the attitude of girls nowadays has also changed. They think that some girls are simply lazy and do not want to work or study. Instead, they hope that when they get pregnant, the father of the baby will marry them and take care of them. Girls also mature earlier than before, and they are therefore also attracted to men at an earlier age.

All groups of FGD participants, women, men, boys and girls, said they condemned premarital sexual relationships. From adults, this attitude would be expected, but it was surprising to hear this opinion from youths, both boys and girls, who are nonetheless often involved in such relationships. The most seriously denounced premarital relationships are those involving secondary schoolgirls and girls still being educated otherwise. These girls were supposed to solely concentrate on their studies and to not jeopardise the financial investment that their parents had made in their education by getting pregnant. Only one group of boys did not blame these schoolgirls for having sexual relationships. They said it is just natural at that age to have a desire to move around with the opposite sex, especially when girls live in 'unnatural' circumstances most of the year, e.g. isolated in boarding schools. During school holidays they enjoy the freedom to interact with boys. The boys perceived the problem to be that these girls and their partners do not know how to use modern contraception and thus get pregnant.

Concerning postpartum abstinence (PPA), a married woman traditionally had to observe a period of two years, to achieve the ideal interval between successive births (see also Mann 1994:173-4; Orubuloye et al. 1993:863-4). FGD participants explained that in addition to the wish for spacing, PPA was observed because sexual intercourse during breast-feeding would pollute the breast milk and thus harm the baby's health. The baby will be sick, have diarrhoea and can even die, especially when the baby is very young, because the sperm mixes with the breast milk (see also Adeokun 1983:132).<sup>13</sup> Some FGD participants mentioned

that using a condom during intercourse, during the time a woman is breast-feeding, could prevent contamination of the breast milk.

Practising postpartum abstinence was reportedly easier in the past. In polygynous marriages, which used to be more common, men would not have to 'bother' their wives who had just delivered. The older women in the FGDs said that if women who recently delivered did not have co-wives, they used to even encourage their husbands to have affairs outside of the marriage, because they wanted to focus their attention on their baby. Some breast-feeding women used to encourage their husband to marry another woman, and some even went to the extent of matchmaking for their husbands. Women were not supposed to refuse sex with their husbands and if they tried to, forceful sex and beating were not uncommon, according to the older women. Most of the older women said there were no other methods of contraception in the olden days apart from abstinence. They said the use of *oruka*, *agbo* and other 'traditional' contraception are recent methods developed by 'modern' traditional healers and TBAs that imitate modern contraception, which corroborates with the TBAs explanation earlier in this chapter.

Despite the conviction that an interval of three years between successive births is healthy for mother and child, all participants in the FGDs believed that women nowadays do not follow the traditional manner of child spacing by two years of postpartum abstinence. They unanimously agreed that the changing society makes it difficult to do so; the monogamous (single-wife) family is on the increase, which makes it hard for women to abstain for two years. They may still practise PPA, but for a shorter period of time, from six weeks to three months, sometimes extended to one year. Young married women said they disliked adhering to a PPA of two years because their husbands would be more or less 'forced' to have extramarital affairs or to marry another woman. Moreover, they pointed to the risks of getting a sexually transmitted infection (STI) if their husbands had extramarital affairs.

### **Perceptions of modern contraceptives**

With the reality of increasing incidence of premarital sex and dwindling postpartum abstinence, the only way to adhere to the traditional rules for child spacing and the prohibition of premarital pregnancy is the use of effective contraception. Therefore, the present study explored the opinions of community groups in FGDs and of women in individual interviews about the uses of modern contraceptive methods, both in general and as used by specific groups of women.

### *General perceptions*

Generally, participants were negative or ambivalent about modern contraceptives. Modern contraceptives may be effective, but they may also impair future fertility, have side-effects and be unreliable. Interviewed women<sup>14</sup> and FGD participants were aware of modern contraceptive methods including condoms, OCP, IUCD and injectables, but believed that particularly OCP, IUCD and injectables may have many adverse effects. Of these side-effects, the most serious is infertility. The high value that Yoruba place on having of children and the stigma of infertility make it no surprise that anything that could possibly interfere with fertility is suspect. Other side-effects mentioned included excessive bleeding, menstruation twice a month and losing or gaining weight. With the IUCD, damage to the womb was also mentioned. In addition to their side-effects, participants doubted the reliability of modern contraceptives; all knew women who had experienced failure of their contraceptives. They reported stories about babies being born with contraceptive pills or an IUCD in their hand. Biomedical staff involved in the present study confirmed this; they too believed in such stories. These stories both bring about and justify opinions about the ineffectiveness and side-effects of modern contraception, and discourage women from using modern contraception. A 42 year-old Christian woman in Lagos told us about her experience with unreliable modern contraceptives during an exploratory interview. She is a small trader with some primary education and has nine children.

When I was young I didn't use any contraception. But when I had my seventh child I decided to go for family planning. My husband is a military man and he did not want to hear about it. So I went on my own. When I first went for coil [IUCD], for about four months nothing happened, but into my ninth month I started feeling somehow. When I went to the hospital to complain, I was told that I was pregnant. I can't abort it again, so I had the baby, which was a girl, in 1990. Then, when the child was two months I went back and started taking injections for about six months and got pregnant again. So when I had the child, who was my ninth child, I decided not to use anything again and my husband is the one who uses condoms now.

The few interviewed women who were more enthusiastic about modern contraceptives acknowledged that they could have side-effects, but that it depended on the 'the body' or 'the body system' of individual users whether they would have problems or not. They also mentioned that pills are only good for women who are not forgetful.

FGD participants did not report adverse side-effects of condoms, but doubted condom reliability for the prevention of pregnancy. They believed that men and women do not like to use condoms because it reduces sexual pleasure and they are cumbersome to use. Some female participants were apprehensive about condoms because they had to rely on men to protect themselves against pregnancy. They suspected some men of recycling condoms, which makes them less effective, and others of piercing condoms intentionally. Women in the surveys were somewhat more positive about condoms, which supposedly do not have so many side-effects and have the added advantage that they protect against sexually transmitted infections.

Tubal ligation and vasectomy are not acceptable to Yoruba for a variety of reasons. Yoruba fear that a sterilised man or woman will be infertile when they are reincarnated, which is a terrible prospect. Secondly, Yoruba do not want to permanently impair their fertility, even if they have completed their family. This would be tempting fate. Human beings can never foresee whether their children will survive them. As was explained before, for parents one of the main values of children is to have offspring to bury them. Their children will remember them and continue the lineage, so that the parents can go to an afterlife and progress in the realm of worshipped ancestors. Some participants considered sterilisation as going against God's work, 'It looks like telling God he did not create well'. Also, given the high value placed on fertility, some women told me that knowing that a woman is infertile would make her less attractive to men and give her less respect in his patrilineage (see also Pearce 1995:200). The unacceptability of sterilisation for Yoruba was proved during the seminar held with biomedical staff in Epe, as a part of the present study. When we presented the figures on contraceptive use in the surveys, the staff could hardly believe that we found *one* woman who had tubal ligation and wondered about what type of woman this could be.

That particular woman was a 40 year-old petty trader in Epe, married with five children. She had never used any contraception before tubal ligation. Her last pregnancy was four years ago and ended in a miscarriage. 'I got tired of pregnancy after I had the miscarriage, so I consulted my doctor. He is a gynaecologist in a private hospital. He explained all the available methods to me and I chose the permanent one. This is four years ago and I am very happy I did it'. The fact that her husband had recently married a second wife might have contributed to her decision to use a permanent method. She may have thought that this woman would now take over the childbearing for the family.

In the interviews with women, some admitted that they had just heard rumours about modern contraceptives, but did not know which methods caused which problems. Because of the rumours they were not interested to learn more

about the modern methods. Some women reported that they did not know anything about modern contraception. It was striking that the opinions about modern contraceptives among women interviewed in the ANC clinic of the general hospital in Epe were relatively more positive than they were elsewhere. This may be explained by the fact that the women coming for ANC services in Epe are always given a health education class by the staff of the FP clinic that is next-door to the ANC clinic, and thus may have more detailed knowledge about modern contraceptives.

### *Opinions about use by specific groups of women*

Most adults in the FGDs were against premarital contraceptive use. They argued that single women simply do not need it because they should not have sexual relationships. Even if girls have sexual relationships, adults discourage the use of modern contraceptives because these could cause infertility and would promote promiscuity. Girls who use contraceptives are called prostitutes and public dogs. Only a few adults said that if girls cannot abstain from sex, it would be better to use contraception to prevent unwanted pregnancy than to risk getting pregnant. However, they warned against OCP for young girls because of the risk of infertility. One adult group said that students should rather use *oruka* (charmed ring provided by traditional healer), because that method is effective and does not have side-effects.

Youth in FGDs and secondary students who participated in the group-work sessions were more ambivalent about contraception for girls and in particular for students. They did not condemn it outright, as the adults did. They were realistic and admitted that premarital sex happens, although they still did not think it was proper. On one hand, the use of contraception by schoolgirls would mean that these girls violated the rule of premarital abstinence, but on the other hand, they would prevent a pregnancy that would be 'proof' that they had transgressed the rule. The knowledge that youths had about contraceptives proved to be highly variable. They mentioned a wide variety of pre- and post-coital contraceptive methods used by single women and their partners; most were not modern methods. Condoms were at the top of the list of methods that schoolgirls and boys knew. OCP only came in eighth place, after other methods not scientifically indicated as contraceptive. These included Schweppes bitter lemon drink, Menstrogen (menstrual regulation drug), potash, Alabukun (an analgesic), drinking lime and drinking local gin. According to them, most of these methods are indeed effective and have the advantage that they do not have adverse side-effects, like the modern methods have. The most serious side-effect mentioned was that OCP, IUCD and injectables may 'destroy the womb'.

Men and women involved in the FGDs were ambivalent about married women using contraception; they saw advantages and disadvantages. In three of the five male FGD groups, participants said that they allow (or would allow) their wives to use contraceptives, whereas in the other two they said they would never agree to it. Most of the men in favour of contraception mentioned that they left it to the experts, either ethnomedical or biomedical, to decide on what type to use, but some said that they would decide for themselves because they have to stay in control. The main reason given why a married woman should *not* use contraceptives implied a fear of reduced male control over the sexuality and womb of his wife: Contraceptive use would help to facilitate wives to have extramarital affairs, because they would not run the risk of exposure by getting pregnant. Moreover, the wives could decide on the number of children to have, while this is traditionally the decision of the man. A second reason to not use contraceptives was the fear that they impair future fertility. Thus, only women with a complete family could use them.

Some participants saw advantages of modern contraception in spacing children, especially for very fertile women, so long as they did not experience side-effects. The opinions about using contraception to stop childbearing varied according to whether participants agreed that interfering with nature and God's wish was acceptable or not. Those who had said that couples should limit the number of children generally were in favour of modern contraception; for women who had enough children the risk of (secondary) infertility was not important. However, interfering with natural fertility might not only have moral objections, but could also be detrimental to a woman's health, which was a third reason for being negative about modern contraceptives, as an older woman in a FGD explained:

There was a woman who had 11 children. After having those children, she started using one of the family planning methods at the request of her husband. Then she became sick. One day, when she was almost dying, she called some of her children who were already graduates and told them that if she should die, they should hold their father responsible for it. She later gave her reasons for making this statement; it [her near-death experience] was due to the contraceptive she used. When it was reversed, the woman got pregnant and gave birth to her 12th child. It was believed that the baby was struggling to come to life. That was why he made her be sick. Now that the woman has delivered the baby, she is as energetic as before.

To summarise community opinions, Yoruba are rather negative about the use of modern contraceptives. Some doubt beforehand whether human beings should routinely interfere with their destiny, i.e. God's intentions for a woman's

fecundity. Furthermore, Yoruba men and women question the effectiveness and seriously fear the side-effects of modern contraception, in particular infertility. Given the focus of Yoruba society on fertility and the negative social consequences of infertility (see Chapter 8), this fear of infertility may well be the overriding reason for not using contraception for child spacing, but only when a woman/couple want/s to stop bearing children. Moreover, contraceptive use clashes with traditional male control over the sexuality and reproduction of his wife, and the rules of premarital abstinence. Contraception makes it easier for wives to have secret extramarital affairs and single women to have premarital affairs. Thus, if women, and in particular single girls and women and those married women whose husbands do not support her, want to go against the rules and take measures to prevent getting pregnant, they usually prefer to do so quietly and in secret.

### **Contraceptive use**

This section first explores contraceptive use among all women in the community survey (whether they had abortions or not). It will be a useful basis for comparison to the next section, which concentrates on contraceptive choices of women who had abortions. In addition to offering statistics, the factors that influenced different groups of women to use contraceptives, or not, will be discussed.

#### *Current contraceptive use*

From the generally negative community opinions on contraception, we would expect the contraceptive use to be low. Indeed, the DHS 1990 figure of contraceptive use among married Yoruba women is as low as 15%, with a ratio of 'modern' to 'traditional' (which included withdrawal, rhythm, and 'others') methods of about 2:1 (Makinwa-Adebusoye & Feyisetan 1994:68).<sup>15</sup> Surprisingly, the present study discovered that 71% of the 460 women in the community survey who did not want to get pregnant at the time of the survey reported they took or did something to prevent pregnancy (Table 7.4).

Table 7.4. Contraceptive methods reported to be currently used by women in the community survey who did not want to be pregnant, by marital status and location (multiple response)

contraceptive category and method	Lagos town		Epe LGA		all* (N=460)
	single (N=83)	married (N=116)	single (N=54)	married (N=193)	
Modern methods	29%	46%	30%	28%	32%
Condom	(12%)	(12%)	(15%)	(9%)	(11%)
Oral contraceptive pills	(13%)	(12%)	(2 <sup>n</sup> )	(6%)	(8%)
Injectables	(1 <sup>n</sup> )	(8%)	(6%)	(9%)	(7%)
IUCD	-	(12%)	(1 <sup>n</sup> )	(3%)	(5%)
Others <sup>1</sup>	(2 <sup>n</sup> )	(2 <sup>n</sup> )	(2 <sup>n</sup> )	(2%)	(2%)
Natural methods	14%	19%	24%	32%	24%
Rhythm	(13%)	(8%)	(24%)	(15%)	(13%)
Lactation	-	(6%)	-	(11%)	(8%)
Postpartum abstinence	(1 <sup>n</sup> )	(6%)	-	(4%)	(4%)
Withdrawal	-	(2 <sup>n</sup> )	-	(2%)	(1%)
Traditional <sup>2</sup>	1 <sup>n</sup>	5%	11%	11%	8%
Substances/drugs not for contraception <sup>3</sup>	23%	3%	6%	3%	7%
Home methods <sup>4</sup>	5%	4%	-	2 <sup>n</sup>	2%
Total any method	66%	74%	69%	75%	71%

<sup>1</sup> Postinor (6), spermicide tablets (4), tubal ligation (1)

<sup>2</sup> Common: *oruka* (28) and *aseje* (4)

<sup>3</sup> Common: Andrew's Liver Salt (10), Alabukun (6), and Menstrogen (6)

<sup>4</sup> Common: drinking salty water or salt in alcoholic drink (6) and Schweppes bitter lemon drink (4)

\* 'all' include 14 divorced women

<sup>n</sup> Numbers are given instead of percentages for figures <3

The conspicuously high figures of contraceptive use can be attributed to the study definition of contraception that looked at intention of the methods and not at the effectiveness, *and* to the choice of the denominator for calculating current use. The denominator for calculating the rate of current contraceptive users only included the 460 out of all the 652 women in the community survey who did not want a pregnancy at the time of the interview. We asked these women 'Do you do anything to try to prevent pregnancy?' and probed for before and after intercourse. Thus, excluded from the denominator were the women who were pregnant at the time of the survey (12%) and the women who wanted to be pregnant at the time of the survey (17%).<sup>16</sup> Obviously these women would be contraceptive non-users. If the denominator would include all interviewed women, as in most other studies, the figure for current contraceptive use of women in this study would still be as high as 50%, and thus considerably higher than the DHS figures for 1990. Other factors contributing to the high

figure would be the wording (not using 'family planning' or 'contraception') and sequencing of the questions. The last column of Table 7.4 shows that more than half (58%) of all contraceptive users (also) used methods other than the 'modern' methods, according to the categorisation as explained in Table 7.3.

The total modern contraceptive use was about the same for single women in Epe and Lagos: 30%, and 29% respectively. For all other contraceptive categories, there were differences between Epe and Lagos and between married and single women. In Epe, relatively more women used natural and traditional methods, while in Lagos, married women used more modern methods. Both striking as well as worrying was the frequent use of drugs not indicated as contraceptives among single girls in Lagos (23%). The use of these drugs was much lower in Epe, at only 6%, and among married women, at only 3% in both Epe and Lagos. The women who were presently using specific contraceptives expanded on their experiences with these methods, which are presented below.<sup>17</sup>

Condoms are the modern method currently most often used by single and married women. There are many stories circulating that women and men do not accept condoms and that they do not like to use them. According to the stories, condoms reduce sexual pleasure and are unreliable because of the risk of breakage. However, the majority of condom users reported that they were satisfied with using condoms as a contraceptive. They liked the double-effectiveness; it is advantageous that condoms also protect against sexually transmitted infections, including HIV. Only nine of the fifty current condom users in the community survey said they were not satisfied with the condom, and mentioned reasons such as the condoms sometimes bursting and reduced sexual pleasure. Four-fifths said to always use a condom consistently every time they had intercourse, while the others admitted that they sometimes failed to use one. Only one woman gave the irregular availability of condoms as the reason for her non-consistent use. This corresponds with our earlier observation that in Nigeria contraceptives, including condoms, are widely available. Other women who did not use a condom each time they had sexual intercourse said either their partners refused to wear one or they used periodic abstinence and only used a condom when they were in their fertile period.

With the exception of one woman, current users of oral contraceptives, IUCD and injectables said they were satisfied with their methods.<sup>18</sup> In addition to the effectiveness of the methods ('it never failed me'), other advantages they mentioned were that the methods were easy and convenient to use and they did not experience adverse side-effects. General comments on the method included, 'It is good for my body'. This is contrary to the community opinions that stress the adverse side-effects of these modern contraceptives. Some of the

women, like this 34 year-old Muslim teacher, had already been using these methods for a long time. This woman is married with four children:

After I had my first child, I got pregnant three times unplanned and went for a D&C [three times]. When the doctor from the private hospital [who performed the D&C] advised me to use pills, I didn't know which one. So in 1985 I went to Island Maternity Hospital and explained [my situation] to the matron on duty. She gave me some pills for 28 days and I started using them. I used to go back every three months for a check-up. When I wanted to have my second child I stopped using them and the next month I was pregnant. When I had my second kid I started with another pill that was also introduced to me in Island Maternity and till now am on OCP without any problem. So I don't know why some people complain that OCP is not good. For me it is okay. I menstruate normally and if I stop it, I will get pregnant between two and three months after.

Of the natural methods, periodic abstinence was the most reported. All except two women (who got pregnant when they were using it) were satisfied with it. Reasons given for satisfaction were that the method was effective, there were no side-effects, it was easy to use and it did not cost any money. The problem with periodic abstinence (also called rhythm method or 'safe period') is that Yoruba often calculate the safe period differently than does biomedicine (as was also illustrated in the reported abortion experiences in Chapters 5 and 6). During interviews and FGDs, most Yoruba men, women and TBAs believed that a woman is fertile immediately after menstruation and is 'safe' midterm, which is exactly the opposite of what biomedicine providers teach about periodic abstinence (see also Akinyemi & Koster-Oyekan 1998:22). Yoruba reason that during menstruation the womb is cleaned of all dirt, including blood and sperm. Just after menstruation the womb is still open and ready to conceive.<sup>19</sup> Only five women reported currently using withdrawal method, but four of them were not happy with this method. Their partner had chosen the method and they felt at risk of pregnancy; one woman had indeed experienced pregnancy while using it.

Lactation method<sup>20</sup> and PPA were reported more by women in Epe than in Lagos, and were often used in combination. The maximum period of time that women reported breast-feeding was seven months. Women seem to see the connection between breast-feeding and the delay of the return of menses after delivery, (which is the sign of not being fertile); they mentioned it in one breath. 'My menses have not returned because I am still breast-feeding my baby'. Postpartum abstinence was reported up to a maximum of one year after the birth of the baby.

Drugs and substances not indicated for contraception that women nonetheless used as such form a highly risky category. Some may have limited contraceptive effectiveness, but they often fail and may have long-term adverse side-effects, including infertility.<sup>21</sup> Some of these methods are used for abortion as well, as explained in Chapter 5. Similar reasoning is used: Because many of these drugs have 'Do not use during pregnancy' written on their prescription insert, women reason that these medicines will also prevent a pregnancy. Most of these drugs (and also the 'home methods' category for that matter) are taken post-coitally. In the course of in-depth interviews with TBAs and women, it became clear that most were of the opinion that conception starts a few days after intercourse. Thus, after intercourse, there is still time to prevent pregnancy. The high use of modern drugs not indicated for contraception, especially among urban girls and single young women (23%), is worrying. Young women of all educational levels use them, even students of higher education, as the following history of a 27 year-old student-nurse illustrates. She told her story in a public gynae clinic in Lagos, where she went because of problems conceiving.

I have been using Menstrogen since 1991 to prevent pregnancy [she has been using it for five years]. However, I still got pregnant five times and did abortion five times in a private hospital by D&C. After my last abortion I stopped using Menstrogen because my menses had become irregular. They were not in the normal flow, but came only in spots.

Current users of traditional methods, mainly *oruka*, were satisfied with their convenient use and their effectiveness. Some women had already been using the method for up to ten years. Several women explained to me that by using *oruka*, a woman could prevent pregnancy without her husband, family or others who she does not want to know finding out. The *oruka* for contraception looks the same on the outside as any *oruka* provided by a traditional healer, such as those for good luck in business or as charm against evil. As mentioned before, it may even look like her wedding ring!

Table 7.5 gives an impression of those groups of women in the community survey most and least likely to use any method of contraception, and more specifically those who use modern contraception. The last but one column gives modern contraception use as a percentage of all contraceptive method use for the specific categories of women.

Table 7.5. Reported current contraceptive use and proportion of users using modern contraception, by women's background variables

<i>characteristic</i>	<i>% use of any contraceptive</i>	<i>% use of modern contraceptive</i>	<i>modern as % of any contraceptive use</i>	<i>N (100%)</i>
<i>age group*</i>				
15-19	46%	14%	30%	44
20-24	76%	26%	35%	137
25-29	79%	36%	46%	99
30-39	78%	41%	52%	108
40-49	56%	33%	60%	72
<i>education level*</i>				
Higher education	80%	47%	59%	51
Secondary completed	78%	43%	55%	161
Secondary not compl.	71%	25%	35%	92
Primary	64%	20%	31%	102
None/primary not compl.	54%	19%	34%	54
<i>marital status</i>				
Married	75%	35%	46%	309
Single/engaged	67%	28%	41%	137
Widowed/divorced	3 <sup>n</sup>	1 <sup>n</sup>	33%	14
<i>setting</i>				
Urban (Lagos)	69%	36%	50%	206
Rural (Epe)	72%	29%	37%	254
<i>All</i>	<i>71%</i>	<i>32%</i>	<i>45%</i>	<i>460</i>

Source: community survey, women who do not want to be pregnant at the time of the survey

\* Chi-square tests found significant associations at  $p < 0.01$  for: Age group: any; modern; (modern/any;  $p = 0.02$ ); Education: any; modern; modern/any;

<sup>n</sup> Numbers are given instead of percentages because figures are too small

Contraceptive use is associated with the age of the woman. Girls below 20 years of age, nearly all of whom were single, used contraception and modern contraception the least of all. Of course, not all of these girls *need* contraceptives; some of them may still be virgins or not currently sexually active. However, the fact that these girls are a group at high risk was already proven in Chapters 4 and 5, because they were over-represented among women having abortions. The highest use of any contraception is in the age group 20 to 39 years, in which the majority of women are married. Although women over 40 years of age used less contraception in terms of actual percentages, they did use more modern contraception *if* they used it. This study supported the general trend that use of contraception is positively related to level of education. Eighty percent (80%) of the higher educated women used some form of contraception while only 54% of women who did not finish primary education did. The differences between figures for modern use were even higher; 47% of the highest educated women

and only 19% of the lowest educated women used these methods. Educated women are probably more used to feeling in control of their lives than lower educated women are, are more motivated to regulate their fertility because unplanned babies may hamper their ambitions and moreover have a greater knowledge of modern contraceptives and how these work in the body. This increased knowledge of modern contraception may ensure that educated women have fewer reservations concerning the side-effects of modern contraceptives.

Married and single women did not differ significantly in their use of any contraception; neither did rural and urban women, with the majority of both groups taking measures to prevent pregnancy. We also explored the relationship between religion and contraceptive use and found no significant difference in any contraceptive use by religious affiliation. However, Catholic women seemed to use modern contraception relatively less (2 out of 17 women) than women of other religions; it seems they preferred to use natural methods of birth control as the Catholic Church advocates. (Figures were too small for statistical tests.)

### *Discontinued use*

Decisions about contraceptives are not made once-and-for-all at the beginning of reproductive life but change with an individual's stages of life and situations (see also Greenhalgh 1995:22-23). Family organisation, marital status, education, economic resources, work, health, number of children, knowledge and accessibility of contraceptives, to name a few, are all situational circumstances that influence contraceptive decisions. Of the 652 women interviewed in the community survey, 69% had been using some form of contraception for some period(s) in their lives.<sup>22</sup> About one third (32%) of these users had tried more than one method, because in the changing circumstances of the course of their lives, certain contraceptives became more attractive. Others switched methods because they were not satisfied with the method they were using, like the following 27 year-old married fashion designer in Lagos explained. She is a Christian who reached class 5 of secondary education and has three children.

My first child was about seven months old when I got pregnant again because I did not use any contraception. So when I gave birth, I started using one tablet that was white and brown [OCP]. When I was using it, I used to vomit and I had sleepless nights, so I changed to Apiol and Steel [a menstrual regulation drug] immediately after intercourse. My breasts were so heavy as if I was pregnant. I got it from a chemist very near my working place. When I could not cope anymore, I went to the *olomo wewe* [TBA] where I used to get medicine when I was pregnant [for ANC]. He gave me some seed to swallow.

Women may discontinue using certain contraceptives for various reasons, e.g. they wanted to get pregnant, the method failed and they got pregnant, or they personally experienced or heard rumours of possible side-effects. The present study was particularly interested in determining why former users of the most common modern contraceptives had discontinued (Table 7.6).

Table 7.6. Reasons why women discontinued use of modern contraceptives, by method

method	wanted pregnancy	got pregnant	experienced side-effect	heard of side-effects	others	N (100%)
Oral pills	50%	8%	26%	7%	9%*	130
IUCD	61%	9%	27%	-	2 <sup>n</sup>	56
Injectables	41%	1 <sup>n</sup>	38%	2 <sup>n</sup>	13%**	32
Condoms	64%	8%	14%	1 <sup>n</sup>	13%***	80

Source: ever contraceptive users in community, ANC and infertility surveys

\* Medication regimen was too complicated; advised by health staff to stop because of her age, over 35

\*\* No money for next dose; advised by health staff to stop because nurse said too much could cause infertility

\*\*\* Partner did not want to use it again; decided to use a more reliable method  
Numbers are given instead of percentages for figures <4

Most women who used modern contraceptives stopped because they got married and/or wanted to get pregnant. However, a considerable number of women stopped using OCP, IUCD and injectables because they experienced side-effects, which is worrying but none too surprising. The main reported side-effects of OCP included bleeding twice a month, spotting, gaining or losing weight, irregular menses, abdominal pains, headache and drowsiness. IUCD users who stopped complained of profuse bleeding and pain. Women who discontinued using injectables stopped because of side-effects such as heavy bleeding, or the opposite, no menses at all. Earlier in this book, I mentioned how Yoruba women consider any abnormality in menstruation as a sign of bad health and especially indicative of disturbances in their fertility.<sup>33</sup> Two women recite their experiences below.

A 26 year-old married Muslim with one child, who has secondary school class 3 education: "I did coil [IUCD] some two years ago. My sister told me about the coil and I went to a private hospital at Itire and did it for 500 naira. When it was about three months I removed it, because I was not feeling fine. I was feeling tired and I got my menstruation twice in a month. I felt as if something was pinning me. I made use of my safe period before, but I do not think I remember [how to use it] again (my sister had explained to me). I have not been introduced to contraceptive pills. My husband is usually in Abuja and I am not ready for another pregnancy."

A 34 year-old married Christian nurse with two children: "I used different types of contraceptive tablets, you know I am in the position [she works in a hospital]. Some of the tablets have side-effects. Some of the tablets made me tired and busy, like the brown and white one [OCP], and there is one brown only that I used and menstruated twice in a month. I used to get it in my hospital, which is a government hospital. My husband does not like coil or that I should use contraception. He said if I use any contraception that it can stop my fertility. I told him that it is not the case that I will not get pregnant again, only that it can take time."

Women who discontinued using condoms complained less about side-effects. Their main objections were related to reduced pleasure during sex, that the condom breaks and that the latex caused rashes.

Overall, just less than one-tenth of women stopped using modern methods because they got pregnant. Except for those using condoms, these failure rates are higher than scientific tests for effectiveness of modern methods calculate, but failure may very well be partly due to incorrect use.<sup>24</sup> With contraceptive methods other than modern ones, the reported failure rates were much higher, proving that these methods are less reliable. Of 87 women who stopped using periodic abstinence, 22% said they stopped because they got pregnant; 24% of the 58 who were using traditional methods stopped because they got pregnant; 35% of the 80 women using various drugs not indicated for contraception stopped for this reason; and 47% of the 53 using home methods stopped because of pregnancy. However, compared to modern contraceptive users, very few women stopped with other methods because they experienced or heard of side-effects. Only the women who had been using drugs not indicated for contraception complained of side-effects: 10% of drug users experienced them (ceasing of menstruation, dizziness) and 9% heard of side-effects.

### *Non-use of contraception*

In literature on contraception mentioned in Chapter 1, researchers point to the inadequate family planning services as the main cause for women to not use modern contraceptives. In this section, women's own accounts are used to show why they don't use contraceptives. From these, it will become clear that reasons other than inadequate FP services are of greater importance. Some reasons for non-use of modern contraceptives differ for single and married women.

The main reason why both single and married women said they had never used modern contraception (although most of these women had used other contraceptive methods) was because of fear of side-effects of the modern methods

and infertility in particular. This was often expressed as 'spoiling', or 'destroying the womb'. A young, married woman in Lagos said, 'I heard from elderly neighbours and friends that it is not good to use modern methods as a young mother, so as to avoid future complications in getting pregnant'. Single women seemed less informed about modern contraceptives, because they talked more in general terms of all modern contraceptives causing infertility, bleeding, miscarriage and a swollen abdomen. In contrast, married women who feared side-effects specified which methods caused particular side-effects.<sup>25</sup>

Other reasons single women offered were that they had never used modern contraceptives because they did not know enough about them. They also thought that they were only for married women, which is a reflection of the unwelcoming attitude towards single women and especially schoolgirls in public family planning clinics. A final reason some of the single women said they did not need contraception (yet), was because they were still virgins.

In addition to their fear of side-effects, married women had various other reasons for non-use. About one-fifth of them said they did not know enough about modern contraceptives or did not know which method they could use. A 25 year-old married Muslim woman in Epe with just a few years of primary education said about modern contraception, 'It is good if used accordingly because it prevents unwanted pregnancy. Maybe if I had been well educated I would have used it'. One 20 year-old recently married Muslim woman with only several years of primary education stated, 'To me it is good, but I am a shy person. Such talk I find it difficult to discuss. Now that I am married, maybe I will go to the nurse who comes to the market'. They had clearly not received sufficient counselling on modern methods.

A considerable number of married women said they did not need any contraception because they did not get pregnant easily, wanted to have many children or they just wanted to wait till they had completed their family. These women did not use any method of pregnancy prevention.

Some women said that they satisfactorily used other methods, including periodic abstinence and traditional contraceptives. Religion, influence of husbands and monetary constraints do not seem to play a major role in preventing women from using effective modern contraception. Just 15 (out of 264) women reported to have never used modern contraceptives because these methods are against their religion. 'I believe that only God can plan the family'.<sup>26</sup> Only seven women said they could not afford to pay for modern contraceptives and four women said that their husbands were against them using modern contraceptives. The finding that male influence was not reported by women in the surveys to play a influential role in contraceptive decision-making contrasts with the opinions of FGD participants, that husbands would not trust their wives to

use contraceptives. Why respondents in the surveys did not mention this more often as a reason, may be either because it *really* did not play a role in women's decisions not to use them, or because it was such an obvious reason that women did not bother to mention it. We neglected to probe further.

A few times I heard atypical cases of married women who never used modern contraception because they preferred abortion. The 32 year-old Muslim owner of a beer parlour who is separated from her husband and has five children is one such woman. She reported that she has had seven abortions.

I don't like contraception at all. I prefer to abort rather than to go on contraception. I have never used any type before. Things that my ears used to hear from people are enough reason for not using. Some people say they vomit when they take it, some say they take prolonged time to conceive which can cause separation between couples. I don't like it, and that is enough excuse if you don't understand me.

The few other women who preferred abortion to contraception considered repeated pregnancies to be proof to their husbands that they were still fertile and therefore still attractive. They also thought that with this demonstration of fertility, the husband would not have a reason to take another wife. Thus, these women used abortion as a way of birth control that suited their needs.

### **Contraceptive use and abortion**

Did women who had an abortion use contraceptives relatively less than community women who never had an abortion did? This would be expected, if we assume that unwanted pregnancy was the result of non-contraceptive use. However, some studies also theorise the opposite, assuming that contraceptive use among women who went for abortions could have been higher than among women who did not have abortions (Llovet & Ramos 1988 and Tietze & Henshaw 1986, cited in Paiewonski 1999:147). These scholars reason that women/couples with contraceptive experience are precisely those who have the strongest motivation to regulate their fertility, and are therefore more likely than their non-contracepting counterparts to resort to abortion when they are faced with an unwanted pregnancy. This theory was constructed in countries where both abortion and contraception services are available and women or couples generally wish to regulate their fertility. Paiewonski did her research in the Dominican Republic where abortion is illegal, as in Nigeria, and her findings support the theory. Our research data allow testing of this theory for

Yoruba by comparing contraceptive use of women in the community to that of the women who had abortions, i.e. who answered the abortion questionnaire.

### *Contraceptive use before abortion*

The contraceptive use of women before their abortion was much lower than the average use in the community, which would counter the theory of Paiewonski. At first glance, only in 30% of the 876 past abortion experiences<sup>27</sup> did women say they had been using any contraception when they got pregnant, while 71% of women in the community survey who did not want to become pregnant were using contraception.<sup>28</sup> However, we have to make some adjustments to get the true picture. Firstly, since the reported abortion experiences date back to the 1970s and contraceptive availability and acceptability may have changed over time, the contraceptive prevalence before abortion for the years during and just before the study is given in Table 7.7. These figures are more appropriate for comparing with the current contraceptive use of women in the community survey. In addition, we have to compare contraceptive use before abortion with that of community women who never had abortions, because having had abortions tends to increase future contraceptive use, as will be discussed later in this section.<sup>29</sup>

Table 7.7. Contraceptive use before abortion, compared to current contraceptive use by women in the community survey who never had an abortion, by method and marital status

<i>category of contraceptive</i>	<i>single women</i>		<i>married women</i>	
	<i>before abortion 1996-1999 (N=149)</i>	<i>Now in commu- nity, never abor- tion (N=97)</i>	<i>before abortion 1996-1999 (N=70)</i>	<i>now in commu- nity, never abor- tion (N=237)</i>
Modern methods	11%	21%	6%	32%
Natural methods	12%	21%	16%	30%
Drugs not for contraception	15%	13%	-	2%
Home methods	5%	2 <sup>n</sup>	-	2%
Traditional methods	2 <sup>n</sup>	4%	6%	9%
<i>Total any method</i>	<i>45%</i>	<i>59%</i>	<i>27%</i>	<i>73%</i>

Sources: 1) community survey, women who did not want to be pregnant and never had an abortion, and 2) abortion questionnaire, women who had an abortion as from 1996 onwards and were asked the question whether they used contraception before abortion.

<sup>n</sup> Numbers are given instead of percentages when figures are <3

Compared to the current use of all contraceptive methods of women in the community survey who did not have abortions, the contraceptive use of married and single women before abortion was lower for all methods, but the difference was only significant ( $p < .001$ ) for married women. However, the

difference for single women would also be significant if we exclude the girls who are not yet sexually active. Modern contraceptive use was much higher among community women who had not had an abortion than among women before they had abortion. Twice as many single women who had never had an abortion and five times as many married women who had never had an abortion had used contraception as women who had had an abortion. This finding therefore counters the theory supported by Paiewonski (1999:147) that argued that women who had an abortion are more likely to be contraceptive users than those who did not have abortions.

In the period 1996-1999, 45% of single women and 27% of married women who aborted had tried to prevent pregnancy. The majority of women who tried to prevent pregnancy before abortion did so with methods other than modern ones; 75% of single and 78% of married contraceptive users used such methods before their abortion. Among women who used contraception in the community survey, these figures were a bit lower, but still as many as 64% of single and 56% of married users, used methods other than modern ones. Significantly, more single women than married women used any contraception before their abortions, which was partly due to the high use of drugs and substances not indicated for contraception among single girls and women (15%). Among single women there were differences in contraceptive use before abortion according to schooling status. Only 21% of secondary schoolgirls were using some form of contraception before abortion, compared to 54% of post-secondary students, 47% of apprentices and 49% of single women not following any education. The trend, judging from contraceptive use before abortion, is an increasing use. Among single women, it was mainly the drugs not indicated for contraception that were responsible for this rise; among married women, it was the greater use of natural methods that was responsible.<sup>10</sup>

The failure of modern contraceptive methods before abortion appeared to be due mainly to inappropriate use of the method and not to method-failure *per se*. Of the 14 women who used oral contraceptive pills, only two maintained they took them correctly but nevertheless got pregnant, while 12 admitted they sometimes forgot to take them. Two women who got pregnant while using injectables said they had missed their appointment. Three women with IUCD said their IUCD got misplaced, which can be considered method-failure. Of the 16 condom users, 13 indicated that the condom burst, while three others said they might not always have used it when they were in their fertile period. From the reports about condom breakage we cannot determine whether the bursting was due to product failure or incorrect use.

The present study assumed that all methods that were not classified as modern have a high failure rate. However, women using them often have confi-

dence in the effectiveness of these methods, as shows from the reports of women who used them. Some women who aborted seemed genuinely surprised that their usual contraceptive method had not worked. A 23 year-old single young woman with secondary school certificate said, 'I used Schweppes and Ampicillin after intercourse, but it failed. I do not know why. I have used it for more than a year'. A 29 year-old married fashion designer with four children reported, 'I am used to drinking Schweppes, or douching myself immediately after intercourse. I cannot explain why the method failed, since I have been using it for a long time – about nine years'. A 25 year-old married housemaid with two children, who finished primary school explained, 'I used *oruka* before, since nine months when I went to Lagos to earn money. I got it from an *olomo wewe* from Epe. It worked very well first, but then I broke the taboo. I was not supposed to eat eggs when I was wearing the ring, or else it would spoil. Well, I shared an egg with my friend and then I became pregnant'. A 25 year-old single market vendor with a stable partner, but without children, who left school in SSS3 recounted:

I did not have sex so often, maybe once a month. I have always used two tablets of Menstrogen every time after 'fun', I never had problems before, but this time I got pregnant. I know about Menstrogen from an Ibo boy who sold drugs on the market beside the stall where my mother sells clothes. I had asked him one time what I could use and he informed me. I never used other contraceptives. I do not like to take drugs, it is not easy to take. I know that some of my friends use Alabukun and Bitter Lemon and *kaun* and hot drink. I have heard stories about condoms that stay in your vagina, so I am afraid to use them.

### *Contraceptive use after abortion*

One would assume that after having an abortion, women would be highly motivated to start using contraception if they did not do so already. Indeed, after an abortion many more women started using contraception, including modern contraception (Table 7.8). Of the 265 women who used contraception before their abortion, 86% continued to use it, while 62% of the 611 women who did not use contraception before the abortion started using it after the abortion.

A positive finding is that after abortion, modern contraceptive use increased considerably: fourfold for single women with about 30% of them using modern methods, and eight times for married women with 41% using these methods after abortion. In fact, the figures on effective modern contraceptive use after abortion for married women are higher than those found among women in the community survey. However, 59% of single users and 34% of married users

continued to use less effective methods. The high use of drugs not indicated for contraception among single women after abortion is especially alarming, but even among married women the use of these drugs after abortion is higher than among married women in the community survey. Natural methods for girls and young women mainly involved periodic abstinence, which is unreliable for girls who often do not have regular menstrual cycles yet and, moreover, do not know how to calculate their safe period.

**Table 7.8.** Contraceptive use after abortion, by methods and marital status (multiple response)

<i>category of contraceptive</i>	<i>single women (N=819)</i>	<i>married women (N=233)</i>
Modern methods	30%	41%
Condom	(15%)	(6%)
Pills	(8%)	(16%)
Postinor	(6%)	(2 <sup>n</sup> )
IUCD	(1%)	(15%)
Injectables	(1%)	(3%)
Others*	(1%)	(1 <sup>n</sup> )
Drugs not for contraception	18%	7%
Natural methods	17%	8%
Home methods	5%	1%
Traditional methods	3%	4%
<i>Any method</i>	73%	62%

*Source:* abortion questionnaire, single women's experiences (missing value = 4) and married women's experiences

<sup>n</sup> Numbers are given when figures are smaller than 5

\* Diaphragm, spermicides

The high use of the emergency contraceptive Postinor after abortion is striking, especially in the period 1996-1999. Eight percent of the single girls were using Postinor in these years, compared to 5% in the years before that period (table not shown). Postinor has been increasingly brought into the market and made more popular through information and an education campaign targeted at adolescents.<sup>31,32</sup> However, girls do not seem to understand that Postinor is reliable as an emergency contraceptive but is not indicated for use as a regular contraceptive. Some girls in the present study used it routinely as their only contraceptive device.

Although it is encouraging that more women started using contraceptives after abortion, we cannot be too optimistic about these increased figures. That more women *started* using contraception after abortion did not mean that they *kept on* using it, as we discovered when analysing the contraceptive history of 234 women with multiple abortions who reported on contraceptive use before and after their abortions (Table 7.9).

Table 7.9. Contraceptive use before and after abortion, by category, for first and subsequent experiences of women who had multiple abortions

category of contraceptive	first abortion (N=234)		subsequent abortion (N=328)	
	before abortion	after abortion	before abortion	after abortion
Modern methods	6%	19%	8%	37%
Drugs not for contraception	8%	18%	9%	14%
Natural methods	8%	18%	17%	14%
Home methods	4%	5%	2%	4%
Traditional methods	1%	1%	2%	3%
Any method	26%	62%	38%	72%

After their first abortion, considerably more women used contraception than they did before their abortion. However, they appeared to have stopped using it after some time. This is demonstrated in the percentages of contraceptive use before subsequent (second, third or more) abortion experiences that dropped considerably from those rates after the first abortion. In an earlier section of this chapter, it was identified that the reasons for discontinuing modern effective contraceptive use were often experience or fear of side-effects, so this might have been the reason for the discontinuation. After subsequent abortions, considerably more women used any contraceptive and the use of modern methods was especially much higher. This would indicate that women learn from their experiences and are increasingly motivated to use contraception. Still, about half of the users used other than modern methods, also after subsequent abortions.

It was striking that more of the women who had had just one abortion compared to those who had multiple abortions, had started using modern contraceptives after abortion: 58% of married and 34% of single women (table not shown). This possibly indicates that this had protected them from recurrent abortions

#### *Non-use of contraception after abortion*

Considering the fact that abortion is not a preferred method of birth control for most women and that the majority of women would not like to have another abortion, it was surprising that 30% of women did *not* start using contraception after abortion. The reasons given by 211 single and 79 married women for not using any contraception can be broadly divided into those that indicated that they were not in need of contraception and those that implied they would have needed contraception (Table 7.10).

Table 7.10. Summary of reported reasons for non-use of contraception after abortion, by marital status

<i>reported reason for non-use of contraceptives after abortion</i>	<i>single (N=211)</i>	<i>married (N=79)</i>
Would have needed contraception	(57%)	(73%)
Ignorance	34%	25%
Fear/experience of side-effects	19%	44%
Others are against	4 <sup>n</sup>	2 <sup>n</sup>
They did not supply her	3 <sup>n</sup>	1 <sup>n</sup>
No need for contraception	(43%)	(24%)
Abstinence	28%	10%
Wants pregnancy, but from another man	11%	11%
Wanted to prove her fertility	3%	3%
No real reason, relies on God	1 <sup>n</sup>	2 <sup>n</sup>
<i>Total</i>	<i>100%</i>	<i>100%</i>

Source: abortion questionnaire, 211 single and 79 married women who did not use contraception after abortion (missing values = 28)

<sup>n</sup> Numbers are given instead of percentages for figures <5

The majority of women who failed to use contraceptives after their abortion (57% of single women and 73% of married) *needed* contraception, because they did not want to get pregnant and did not intend to abstain from sex. The reported reasons for not using any contraceptives were the same for single and married women, but differed in relative frequency. The majority of single women and a minority of married women who needed contraception said they did not know which method would be most suitable for them or were not aware of contraception at all. Evidently, the abortion provider had not counselled these women on contraceptives they could use after their abortion. The majority of married women and some single women said they were afraid of the side-effects of contraception, including infertility. Some had already experienced side-effects and others had only heard about them. A single 24 year-old woman who had finished secondary school said, 'I learned from friends that contraceptives are very injurious to health and that is why I did not use them'. Another 22 year-old single woman said, 'My friends told me that family planning is only for married women. If a single woman takes them, it may make her barren'. Only a few women said they did not start to use them because other people were against them using contraception. These 'others' were parents, partners or church leaders. Some women also reported that they did not use them because the abortion provider did not supply them.

The remaining women who did not use contraception after abortion (43% of single and 24% of married women) did *not need* contraception, mainly because

they reported that they abstained from sex after their abortion. Other women who did not need contraception wanted to get pregnant as soon as possible (some explicitly said 'to prove my fertility'), but this time from their regular partner and not from the person who impregnated them before. The married women who said this usually had an unwanted pregnancy through an extramarital affair, while the single women became pregnant from a casual friend they would not want to marry, or after being raped.

### *Post-abortion counselling on contraceptives*

The majority of women had their abortion in private hospitals. One would expect these providers to supply them with contraceptives afterwards or to at least give information and counselling, to prevent unwanted pregnancies and abortions from recurring. Providers other than private practitioners could have at least counselled the women on contraceptives. Many providers, however, missed the opportunity to offer contraceptive counselling to their abortion clients. The absence of contraceptive counselling is not a situation peculiar to Yoruba society or to Nigeria, but reported in many studies as compiled in Indriso & Mundigo (1999:39). Of all 184 women in the present study who had abortions to whom we asked whether the abortionist they went to counselled and informed them about contraceptives, only 58% said they received any information.<sup>33</sup> However, this was the average for all women; some categories of women, especially young schoolgirls, were hardly given any information. That this lack of information might have been an important reason for them not to use effective contraception after their abortion is shown in Table 7.11.

Table 7.11 indicates a positive association between receiving post-abortion contraceptive counselling from the provider and post-abortion use of modern contraceptives. Moreover, the table makes blatantly clear that single women, girls below 20 years-old and primary and secondary school students got relatively much less information than other categories of women, use less modern contraception post-abortion and are therefore at higher risk of recurrent unwanted pregnancy and abortion. The reason why these young girls did not receive information and counselling has to be sought in the attitudes and opinions of most providers, who believe that single women, and especially schoolgirls, should not have sexual relationships, and therefore do not need contraceptives. As discussed earlier, providers reason that telling these girls about contraception would mean endorsing or even promoting premarital sex.

**Table 7.11.** Women who got contraceptive information from their abortion provider, and started using modern contraception after abortion, by age, education and marital status

<i>background characteristics of women aborting</i>	<i>% information on contraception from abortionist</i>	<i>% use of modern contraception after abortion</i>	<i>N</i>
<i>age group*</i>			
Below 20	28%	19%	43
20-24	61%	35%	80
25-29	70%	60%	43
30 and over	89%	50%	18
<i>schooling status*</i>			
Primary/secondary student	19%	7%	27
University student	71%	38%	45
Apprentice	36%	23%	22
Not in school	69%	52%	90
<i>marital status*</i>			
Single/engaged	53%	34%	156
Married	86%	62%	21
Divorced	86%	71%	7
<i>All</i>	<i>58%</i>	<i>39%</i>	<i>184</i>

*Source:* abortion questionnaire, 184 women who went to a provider for abortion and were asked about whether the provider counselled them on contraception

\* Chi-square test shows significant associations at  $p < 0.01$  for all the background characteristics/receiving information and background characteristics/use of modern contraception after abortion

## Premarital abstinence

Though most community members condemn premarital sex, it is increasingly common. But how common is it? From findings in the present study, we can deduce that present-day premarital abstinence is the exception and not the rule. Only 14% of the total of 137 single community women who did not want to be pregnant said they did not need contraception because they were still virgins. This indicates that the other 86% had disobeyed the rules of premarital abstinence. Abortion histories in Chapter 5 illustrated how girls and single women more or less willingly had sex for a variety of reasons. They had sex with their stable boyfriends as an expression of affection and love, or had a casual affair and enjoyed the money and gifts this often brought them or tried to motivate their boyfriends to marry them officially by getting pregnant. Other girls had sex less willingly; some girls were coerced by their partners into having sex or were raped.

In this section I want to pay special attention to the premarital sexual relationships of secondary schoolgirls because findings of this study supported the

conclusions of researches in Nigeria and other African societies (Bleek 1976; Caldwell 1994; Koster-Oyekan 1999; Van den Borne 1985) that these girls constitute a high-risk group. Schoolgirls often resort to unsafe abortion and suffer the complications thereof.

It is difficult to measure the incidence of the involvement of secondary schoolgirls in sexual relationships. Of the 67 secondary schoolgirls aged 13-19 involved in a sexuality education project that I initiated as part of this study, just 10 (16%) reported in a self-administered questionnaire to have had sexual intercourse (in comparison to 47% of the 74 boys). Three of the six girls who specified how sex happened said it had been a mistake, two said that they wanted it and one that she was forced to have sex. The majority (70%) of the boys who had sex said they had wanted it. Of the seven secondary schoolgirls whom we interviewed in the community survey for the present study, three had begun sexual relations and four said they were still virgins. (All three sexually active girls reported to use contraception: two of them 'safe period', and one oral contraceptive pills and condoms provided by her boyfriend).

Schooling is the reason why many students both want and need to postpone marrying and childbearing. At the same time, if the school is coeducational or mixed, it is an opportunity to be in daily contact with age mates of the opposite sex. Even in an only-boys or only-girls school, there are opportunities to meet with students of the opposite sex, e.g. at sporting events, parades or cultural competitions. Male and female students offered insight into how schoolgirls end up going against the teachings of their parents through focus group discussions, group work sessions and stories students wrote on the abortion experiences of schoolgirls. The 106 written stories, 44 authored by boys and 62 by girls, which had to be realistic or true, were especially informative about what youth think of sexual relationships and abortion.

In the course of the FGDs with youths, it became clear that sex is an ambiguous issue for girls, and not always solicited, because of the differentiation that was made between sex that was not really the girl's fault and sex that was. They condemned girls who have sex without any 'legitimate' excuses such as poverty, home problems, rape or being influenced by bad peers, as being immoral. Some of these themes were also illustrated in the written stories, parts of which are presented below, unedited. The beginnings of these stories illustrated how sexual intercourse of schoolgirls came about and where the youths actually have secret sex. (I summarise the conclusion of the stories.) Adenike, a female student, wrote a story about a girl named Benita who was from a poor background and had to give in to the sexual advances of a teacher in order to get money for her exam fees. Students pity such a girl when she gets into trouble.

*The Evil Samaritan Mr. Jimmy* – story by Adenike

... A year after the divorce, Mr. Raymond had a motor car accident. So, this turned the man to a beggar, because he had decided to do all his best possible to send his only daughter, Benita, to school. As Benita continued to go higher in her education, things began to be more difficult for her father and her. One day, Benita's class teacher (Mr. Jimmy) noticed that she was crying secretly, so he called her and asked her what was happening. Benita explained all her predicament and the teacher promised to help her whenever the need arise. When Benita got home, she told her father about her teacher but her father grew furious and warned her not to go with the teacher, that he would continue to overwork himself to get her the best of education. Benita did not take her father's advice, because her father could not provide all her needs at school. Students just resumed from vacation when the school vice principal announced that the WAEC fees were 1,850 naira. The news shocked Benita, because her father was sick at this time of announcement. So she did not bother to tell her father but went to Mr. Jimmy's house and told him the news. Mr. Jimmy asked her to come back the next day. When she arrived at Mr. Jimmy's house, Benita was seated down by Mr. Jimmy while he went into his room in pretence to bring out the money. (...) When Mr. Jimmy came out of the inner room, he promised to give Benita the money on the condition that she would sleep with him. Benita wept uncontrollably, but had to accept the condition since she had no other hope. (...) As Benita was dressing up after the bitter moment had passed, Mr Jimmy threw 2000 naira on the bed for Benita. [When she got pregnant, Mr. Jimmy helped her to go to a quack doctor. When complications developed three days later she was brought to the hospital. She'll have to spend the rest of her life infertile, which is a tragedy.]

Students sometimes accused parents of being the cause of their daughters' sexual affairs. Fathers and mothers may set a bad example by (openly) having multiple partners. On the other hand, students may find that their parents are to blame because they either are too strict or give their children too much freedom. In both cases, the girls are prone to sexual exploration. The story below, written by two boys, Tunde and Alabi, shows how Lola ends up in trouble because she got too much freedom at home.

*Life on the wild side* – story by Tunde and Alabi

Apart from Lola there were two other boys in their family of three of which Lola was the eldest. Because of her first child status her parents gave her a bit too much freedom. Allowing her especially in her teenage years opportunities to go out to parties without asking for the address or how long it was to last. So

sometimes she would give an excuse that the place was far so that she could not come home that night but actually it was a night party. Even in school she was always dodging the security guard so she would be able to get out of the school and go to a party somewhere. While all this was happening her parents had no idea of what was going on, because Lola wasn't close with her parents. Her father was always working late at his office leaving only her mother to talk with, but her mother never discussed issues about growing up such as sex education and responsibilities of freedom with her. The best her mother did was to tell her to focus on passing her exam and advise her to stay away from boys. However, the advice only made Lola curious to know why it was bad to be close to boys or have boy friends. She did not know that her curiosity would lead her in a very shameful situation. It happened that Lola went to see her friend called Vivian so they could go together to a party at Mushin. When they got there they started to enjoy themselves. Later Lola met a guy called Fred Chukwu who was twenty-two years old and was a successful spare part dealer at Idumota [area in central Lagos] where he also lived alone in his apartment that was near Lola's street. From then on their relationship became intimate and loving. Though Lola was only 17 years old she did not mind seeing the relationship as an adventure. Lola and Fred were very close and they would go to places together when it was weekend or during the holidays. Still Lola's parents knew nothing about her relationship with Fred. Fred would always come to see Lola in her school during closing hours or at break-time but he never went to her house. Initially Lola was a virgin when she met Fred and even some months into the affair they still had not slept together, but Fred was anxious and told her that if they loved each other they should be able to show it through sex. At first Lola was sceptical but later she finally gave in when she went to see him at his place during her school holidays. After the first experience of intercourse Lola did not feel scared but pleased that she had gone through it with Fred. Afterwards Lola and Fred would go out to parties and enjoy themselves while later they would have sex but during their lovemaking they would not use condoms because both of them knew nothing about such things. They did not know that would lead them especially Lola into trouble. [When Lola got pregnant, Fred helped her to buy drugs for self-abortion. Heavy bleeding started at school and she was brought to a hospital. Luckily she did not have lasting complications.]

Peer pressure, either positive or negative, is a very influential factor in the behaviour of adolescents. An innocent girl who happens to move around with 'bad' company may forget the teachings from home. Even girls from respectable homes will succumb to the pressure from their peers to conform to

standard conduct, including having a boyfriend and having sex. Fakoya, a female student, wrote a story about Jessy that shows that a girl who is treated too strictly by her parents, may be especially susceptible to peers' influence about what is appropriate sexual behaviour.

*The price of abortion* – story by Fakoya

They lived at one of the beautiful part of Lagos State around Victoria Island. Throughout her primary level of education she was taken to school by her dad and in the afternoon her dad's driver – Uncle Bassey – picked her to their house after school. There was no time for her to play with her friends after school hours. (...) After her primary school (...) Jessy turned up to be a day student in a very big and popular secondary school called Saint Agnes Girls High School. Things started happening as of before. She was being carried to school by her father's driver in the mornings and returned with the driver immediately after school without waiting. All these went on till she was in SSS2 and she was very worried about it, no time to play with friends. She goes back to her house where she does not have a single friend. Jessica does complain to her friends and they do feel sorry for her because they on their own are really enjoying – they have boy friends at home and they are already disvirgined. Jessica feels like having a boy friend because her friends tell her that there is fun in it and it is very interesting but where is the chance? The time of examination arrived, although Jessica did not read very well for the examination, but she still made it to the next class SSS3. During their first term in the new class things were going on well for Jessica, but the thought of having a boyfriend abode in her mind. One sunny day after break time, one of Jessy's friends called Susan brought news about a social gathering that will take place in a neighbouring school which is a mixed school, comprising of boys and girls called Victory High School. Susan told that their school was invited. They were happy about the event, but Jessy was confused because she knew there is no chance for her to go there. Jessy told her friends about her situation, that she was interested, but there is no chance for her. After deliberating on it, one of her friends called Kemi taught her a way to trick her parents and her driver. The D-day came and they all brought their outfit. After school that day she tricked her driver by telling him that he should come back around 5 o'clock, that they were going to have an extra lecture. The driver insisted on taking her home, but Jessy pretended to be annoyed and saying if she fails her exam for not taking part in the lecture the driver is to be blamed. So the driver went away and Jessy had a chance. Jessy and her friends put on their outfits, which were very attractive. Jessy wore a blouse revealing the top of her breast and a mini skirt and a high heel boots. When they arrived at the gathering there were a lot of boys and girls

here from many schools. When the program started the students entered the hall and some of them were called up the stage to come and dance. Jessica was among the students. At first she was afraid as she walked up the stage to come and dance. Later a boy approached her for a dance. Firstly she was shy, later she let him and they both talked and introduced themselves as they were dancing. The boy's name was Tayo Bello, a tall slender boy with scars [tribal incisions] all over his face about the age of 18. He had a bad behaviour, he smoked cigarettes and did a lot of rubbish. Tayo hid his behaviour while dancing with Jessy. After dancing for about 30 minutes they went out of the hall to an abandoned building in the school. When they got there, Tayo started telling Jessy about boys and girls relationships and how interesting it is. Tayo now seeing that Jessy was in the mood, kissed her neck down to her chest. Jessy was carried away by this act. Soon Tayo mounted her so hard that she was about to scream, but he covered her mouth. When Tayo stood up, Jessy had tears rolling down her cheeks, but at the same time she was laughing. He then asked her what was wrong with her. She then smiled and said it was painful. Then Tayo asked her if she enjoyed it and she answered 'yes'. [When Jessy found herself pregnant she went to Tayo who now showed his real character and denied responsibility. Her friends advised her to have an abortion, which she did, at a quack's place. He used a pair of scissors and some other equipment which he dip inside her vagina in order to cut out the foetus, but mistakenly he damaged her womb. She had complications but kept on hiding. Her parents who noticed their daughter was not well sent her to a doctor who told them what happened and that she is infertile now. The father sent her away from the house and she ended up selling iced water and helping lifting goods at the roadside.]

A boy may emotionally force a girl to have sex with him, because he wants to have 'proof' of her love for him. A girl who has a serious boyfriend (a boy she really likes and would like to 'keep'), but does not have sex with him, may give in to his wishes in the end. She may be afraid of losing him to other girls who do not mind having sex with boys.

Boys as well as girls in FGDs and group work, stressed that some schoolgirls have sexual relationships of their own volition and thus have no one but themselves to blame when they end up in trouble. These girls may not be serious about their studies; they may seduce a teacher in order to get a passing mark. Or, they may prefer to enjoy themselves in the company of 'loose' girls and men. Their 'nature' is to want to explore and become involved with the opposite sex. Some girls have enough money to pay for the necessities, but are unsatisfied; they are jealous of other girls who have more fashionable clothes and

shoes, expensive hairstyles, make-up and jewellery. They are greedy and will have sex in return for money and gifts.

The stories the students wrote were generally less moralistic about sex than the statements that boys and girls made in the group discussions were. The picture arising from their stories is that schoolgirls often have sex as an expression of love for a certain boy or man. More than half (54%) of the stories written by boys and half of stories by girls concern sex resulting from mutual consent between lovers (see parts of the story written by Stephen). The girls in these stories find different excuses to tell their parents in order to be able to see their lover. They may say that they are going to stay with a relative or friend, or that they are going to fetch water or that they have study classes after normal school hours. A considerable number of students wrote stories in which sex just happened unplanned, as a consequence of 'innocent' attraction between a schoolgirl and schoolboy who happened to find themselves in a situation conducive to sex, although more boys than girls reported such stories.

*The experiences of a schoolgirl who aborts her pregnancy* – story by Stephen

... Jane was a responsible girl in her family from childhood and because of this fact, her parents decided to sponsor her in education without caring that they were poor. (...) During the school holiday Jane travelled to spend her holiday in Lagos, where she met a boy who introduced himself before her. He told her that he has interest in her and also that he likes the way she behaves to people. The boy by name Mark attracts Jane the first time she saw him. Surprisingly they were from the same town. (...) Their relationship started growing and they loved each other. One thing that always made Jane angry was that Mark wanted to have sexual intercourse with her which she disliked. Both of them were friends, but despite this, Jane did not want any interrelationship between her and Mark. (...) One day something unusual happened. Mark invited Jane to his birthday party and all his friends as well. That was the first day Jane attended a friend's birthday party, she enjoyed all the fun and the meal served by Mark. Mark invited Jane inside his room. That was the first experience that Jane had about kissing and sexual intercourse. Mark disvirgined [deflowered] Jane. Their friendship became so serious that no man on earth could separate them. [Jane gets pregnant and Mark assists her financially to go to doctor for abortion. She has complications that she tries to hide. After some time her uncle, whom she stayed with, notices something and sends her to his hospital where the doctor discovers what she has done. Still she denies it. When she is well again after a long treatment, her uncle sends her home to her parents. Her parents also send her away because she has disgraced them and so do Mark's parents where she went. In the end she becomes a prostitute and still dies of

the consequences of her abortion. Stephen concludes with saying that 'Jane, as many other young girls died because of lack of sex education'.)

Youth in FGDs did not mention the influence of American and European films and music, which they nonetheless like watching and listening to frequently. This 'foreign culture' that promotes alternative lifestyles, pictures the ideal of romantic love and often implies premarital sexual relationships, appeals to young people. In some written stories the male character tried to put the girl in the mood for lovemaking by watching a 'blue' movie together.

No discussion of contraceptives appeared in most of the stories. In only 13 of the 106 stories did either the storyteller or the story character mention contraception, but in these 13 stories the author observed that the characters did not use contraception or the characters used it but it failed. Not one student mentioned successful use of contraceptives. Two stories included the common myth that a girl could not get pregnant from the first time she has sex.

Youths envisioned mostly negative consequences of breaking the rules about premarital sex and having an abortion. About three-quarters of the 106 stories ended badly, either the girl died, became infertile and/or her parents disowned her and sent her away. In 12% of the stories, the girls did not have lasting health consequences, although their parents or school authorities made them stop their education. Only in 14% of the stories did the girls recover and could continue their life as before.

## Conclusion

The figures on current contraceptive use among women in the community survey (71%) were much higher than in other studies and the official DHS figure of 15%. We can deduce that women, both single and married, have a need for effective contraception from the fact that so many tried to prevent pregnancy with ineffective or less effective methods. The need for effective contraception can also be deduced from the high incidence of unwanted pregnancy and abortion, in view of the finding that abortion is not preferred over contraception as a method of birth control.

The findings about the high intention to prevent pregnancy but relatively low use of modern contraception in the community at large as well as among women who aborted, obliges us to concentrate on the question why many women choose to use methods other than modern ones. Hypothesis 1, presented at the beginning of this chapter, that modern contraceptive services and devices are not available has to be rejected, because they are usually on the shelf

in public family planning clinics, chemist shops and pharmacies. Hardly any of the respondents complained about the non-availability of devices.

The reasons for the relatively low use of modern contraception relate partly to sociocultural influences (hypothesis 2). Modern contraceptives are shrouded in ambiguity for the Yoruba. On the one hand, Yoruba believe these methods are effective, possibly too effective, because in addition to preventing unwanted pregnancy at present, they might impair future fertility. On the other hand, they talk about failure of methods and their fear of side-effects (see also Hardon 1995:35-40). Because fertility is central in Yoruba culture, as it is in many other societies, anything interfering with it is suspect. Because Yoruba believe that most modern contraceptives (condoms are an exception) may impair future fertility, they dislike these methods and would rather use other contraceptive methods that they believe do not have a negative effect on fertility.<sup>34</sup> The stories about side-effects and failure of modern contraceptives are pervasive. Some of the minor side-effects, which do not affect health according to biomedicine, are perceived by Yoruba to be detrimental, especially when the methods cause a change in the menstrual period or result in intermittent bleeding. Any irregularity in timing, amount of blood, duration of bleeding, colour, odour or substance may be a sign of a reproductive health problem – mainly affecting fertility. Moreover, Yoruba interdict intercourse during menstruation, because the blood is considered polluting and dangerous for men's health, so intermittent bleeding is inconvenient because it increases the number of days of forced abstinence (see also Pearce 1995:199).

Other sociocultural factors influencing modern contraception (non-)use relate to dominant rules and to male control over the sexuality of their daughters and wives. Use of contraception connotes immorality because women may use it to hide secret premarital and extramarital sexual affairs. For single girls, using routine modern contraception or even carrying condoms implies that these girls admit to themselves and their partners that they are breaking the rules for premarital sex. This may contradict their moral self-image.<sup>35</sup> Post-coital contraceptive methods (effective or not) are better for preserving their moral self-image, because of the impression they only need 'emergency methods'. Moreover, most of these methods are favourable for maintaining the secrecy of the affair because most post-coital methods can either be bought without disclosing to the chemist or drugs peddler that they are going to use it for contraception, or the methods are already lying around in the house.

The circumstances of sexual activity of most young girls also favour post-coital methods over routine contraceptives. Sexual intercourse was often not planned for and not frequent. First intercourse was usually the result of the boy or man taking advantage of a favourable time and place.<sup>36</sup> This irregularity and

unplanned nature of sex for most young single women makes it difficult for them to plan in advance for contraception (carrying condoms) or use routine contraception, i.e. pills or IUCD.<sup>37</sup>

Married women who want to prevent pregnancy even when they are not involved in extramarital affairs will often have to do so secretly. They are supposed to bear children for their husbands' patrilineage and be faithful to their husband. In-laws and possible co-wives closely watch the wives, and any flaw, suspected or real, would be a source of discussion and gossip. Since effective modern contraception carries ambiguous connotations of promiscuity and extramarital affairs, other women, including in-laws may gossip about her using it, even if her husband has agreed to it. In-laws may also doubt her commitment to producing children for the patrilineage. The fact that methods other than modern ones can be used more secretly could partially explain the high use of other methods among married women (in addition to the fear of side-effects).

An additional factor heard in exploratory interviews and informal conversations that influenced couples, but particularly men, to not want to use contraception to limit the number of children, lies in the political sphere that is more the domain of men than of women. The Nigerian population policy advocates four children per woman, in order to curb the explosive national population growth and to improve the health of mothers and children. However, because the political inter-ethnic relationships in Nigeria are tense, some Yoruba do not want to deliberately limit their family size and risk becoming a minority compared to the two other major ethnic groups in Nigeria, Hausa in the North and Ibo in the East.

Contraceptive commodities are available from different providers. However, the services are not accessible to all women (hypothesis 3). The use of contraception by single women is not accepted by societal rules. Unofficial policy also prevents single girls from getting contraceptives in public FP clinics. Also, some married women do not like to go to a public FP clinic if they do not want to disclose that they intend to prevent pregnancy. Moreover, they might find going to a public FP clinic to be too time consuming. Thus, many single women out of necessity, and married women mainly out of preference, get contraceptives from chemist shops at which they are given little, incorrect or no information and may even be given ineffective contraceptives. Chemists supply OCP and condoms, but were also found to prescribe all sort of drugs to be used as a contraceptive (see also Otoide et al. 2001:80).<sup>38</sup>

Women and men do not have enough information and knowledge about modern contraception (hypothesis 4). Because of the ambiguity surrounding contraception, a lot of gossip and hearsay circulates about the side-effects and unreliability of them, which in turn nurtures their ambiguity. Stories are passed

on over and over again, about women whose fertility was impaired, who suffered from serious side-effects and who got pregnant using modern methods. Sadly enough, the routine use of modern drugs not indicated for contraception may cause more adverse side-effects than modern contraceptives, e.g. infertility, hormonal imbalance and immunity to antibiotics. Unfortunately, no rumours circulate about the side-effects of drugs not indicated as contraceptives.

Many respondents who were asked their opinion on modern contraceptives admitted they had only heard rumours about them; on these rumours they based their decision not to use them. Only a few women displayed a thorough knowledge. This is due in part to providers who purposely withhold information from some groups (e.g. youth), and to women who get their devices at places where no thorough counselling and information is provided. This may explain why so many women reported having stopped using modern methods because of the side-effects. They anticipated side-effects because they had heard about them from rumours. However, many of the reported side-effects would have subsided after the first three months of use, something that proper counselling and information would have explained. Most women who stopped for reasons of side-effects did not know this and stopped after one or two months' use. The scarcity of information and counselling may explain the high incidence of incorrect usage and failure of modern contraception, and the high use of other methods that the present study identified (hypothesis 5).

It is not surprising then, that the majority of the women who had an abortion did not use modern contraception. They either did not use any, or used ineffective means, because many sociocultural and service related factors discouraged modern contraceptive use, especially for young single women. Fear of infertility is a major factor discouraging use of modern contraceptives. Ironically, the ultimate result of this non-use is frequently exactly that: infertility resulting from a botched abortion. This theme of infertility as cause and effect of abortion will be elaborated on in the next chapter.