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Secret strategies: Women and abortion in Yoruba society, Nigeria

Koster, W.

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INFERTILITY

'Infertility' has been a theme that has arisen in various places throughout this book. Disproving infertility was identified as a reason for premarital pregnancy in some poorer sections of Yoruba society. It emerged as a legitimate reason for divorce, as an expected and actual outcome of a botched abortion and as a major factor influencing non-use of modern contraception. Inhorn (1994a:459) wrote: 'Infertility provides a convenient lens through which issues of fertility can be explored. Indeed, infertility and fertility exist in dialectical relationship of contrast, such that understanding one leads to a much greater understanding of the other...'. To be able to analyse the role of infertility in induced abortion, this chapter takes a closer look at the preoccupation with fertility and infertility in Yoruba society. The chapter will focus on community perceptions concerning infertility, on the coping strategies that infertile women adopt and the experiences of infertile women, especially where it concerns the relationship with their husbands and in-laws.

Sources of information

Most of the data presented in this chapter is qualitative. The purely qualitative data originate from in-depth interviews with women, biomedical and ethno-medical service providers in the exploratory phases of the study; from FGDs with community women and men; from group sessions and in-depth interviews with TBAs and from interviews with other service providers of infertility treatment. The semi-structured interviews with women in the infertility, ANC and community surveys, and the self-administered questionnaires by secondary school students provided qualitative and quantitative data.

Table 8.1. Sources of information for Chapter 8: Infertility

<i>study populations</i>	<i>sample size / data collection methods</i>
Infertility clients in infertility survey	69 interviews (53 at public hospitals, 16 at TBA clinics)
Women with (past) infertility problems	37 interviews (27 in TBA clinics, 7 in community, 3 at public hospitals)
Women in ANC and community surveys who (ever) had infertility problems	163 interviews (118 in community survey, 45 in ANC survey)
Secondary school students	196 'complete the sentence' questions in self-administered questionnaire
Community groups	5 focus group discussions older women, 5 with younger women and 5 with men
Traditional birth attendants	42 in-depth interviews; discussions and group work during workshops
(Other) providers of infertility treatments	Interviews with several biomedical health staff, one <i>woli</i> (prophet) of the Celestial Church and one <i>babalawo</i>
Women with abortion complications in hospital	41 in-depth interviews
Community women (through networking)	7 in-depth exploratory interviews

Definitions

The official WHO definition of infertility is 'the failure of a couple to establish a pregnancy after one year of having unprotected sexual intercourse, no matter whether there was a pregnancy before or not; i.e. secondary or primary infertility' (Okonofua 1996a:1). Some demographers define infertility using longer periods of time.

The word for infertility in Yoruba language is *airòmòbí* (literally: unable to bear child). Yoruba further differentiate between types of infertility: never having conceived, never having delivered a live birth, not having living children and having only one or two children. Barrenness (i.e. never having conceived) carries the highest stigma and having only one or two children and being unable to have more, carries the least. Yoruba give barren women nicknames such as *agan* (barren, held in contempt) or *akò* (male). *Okobo*, which means 'impotent', is the nickname for an infertile man. Women who got pregnant but have never delivered a live baby, (i.e. who had a miscarriage or stillbirth), or women whose child(ren) died at a young age are called *iya abiku* (mother of *abiku* children). *Abiku* are believed to be spirit children that are born to die or die when still in the womb. These women have at least proved that they can conceive and therefore are generally more respected than women who have never been pregnant. Women may also have 'only' one or two children and then after that may be unable to conceive more. This can cause problems in the relationship with the

husband and his family who might mistreat the woman, but there is no special name for these women.

This study considered a woman or man as having infertility problems when (s)he reported problems conceiving or producing a live birth. Most, but not all of the reported infertility did fall within the WHO definition of one year.¹ The terminology and definitions that I use in the present study are as follows:

- *Infertility*: perceived problem of conceiving or producing a live birth (also when a person already has children, and not necessarily conforming the official WHO time period of one year);
- *Barrenness*: inability of a woman (ever) to conceive;
- *Sterility*: inability to impregnate (man) or conceive (woman);
- *Childlessness*: having no living children. A childless woman may be barren, but could also have conceived and lost her pregnancy due to miscarriage, abortion, stillbirth or ectopic pregnancy. Her child(ren) also could have died after they were born;
- *Sub-fertility*: having at least one living child, but having perceived problems either in conceiving another or producing a live birth.

Barrenness and sterility constitute primary infertility, childlessness could be due to primary or secondary infertility and sub-fertility is always caused by secondary infertility.

Sympathy and accusations

Community perceptions of infertility, which reflect societal rules and norms, form the reality in which infertile women and men must live. Participants of FGDs conducted in the community all said that infertility after marriage is a serious problem. They shared their perceptions about couples without children and what they would advise them to do. Generally, both infertile men and women are pitied for their predicament and people sympathise with them. By using proverbs, community members speak words of encouragement and hope. These proverbs show the generally optimistic nature of Yoruba. Some proverbs draw an analogy with fruits or animals that have many offspring, some give consolation that God will provide children, while others just picture the happy future; most proverbs are directed at women (see Table 8.2).²

Table 8.2. Yoruba proverbs to encourage infertile persons, with English translation

<i>Yoruba proverbs about infertility</i>	<i>English translation</i>
<i>Ogede kii gb'odo, ko ya agan</i>	The plantain (banana) tree does not stay within the stream or river and remain without offspring [The husband is the river]
<i>Esuru kii ya agan</i>	The yellow potato does not remain barren
<i>Abimo le'mo ni t'eku eda</i>	The rat gets plenty of children
<i>Olorun a si e ni inu</i>	God will open your womb
<i>Ile aanu Oluwa kii su, asiko Oluwa loju</i>	The Mercy Land of God does not get dark or cloudy, God's time is the best
<i>Agan a t'owo ala bo osun a fi pa omo ni ara</i>	A barren woman will one time dip her hand into red powder [traditional medicinal powder to smoothen the skin of the baby and to clean rashes] and use it to rub the baby's body
<i>Bi ako baku, ise ko tan</i>	If you don't die, you can still do so many things [as long as there is life, there is hope]

Family members and community members advise the infertile couple on bio-medical, ethnomedical and spiritual treatments; they pray for them and continue to encourage them. Concerned in-laws are said to take the wife for treatment. Because infertility is often believed to not be the fault of the persons concerned, most community members sympathise with infertile women and men. Infertility may be a person's or a couple's destiny. Since community members consider God the ultimate giver of children, they reason one should not abuse infertile people, because by doing so one would abuse the work and the will of God. Others believe that another cause of infertility for which persons cannot be blamed might be that evildoers put a curse on them. When this is suspected, community members advise the couple to visit a *babalawo* (Ifa priest) who will consult the oracle to discover the cause and treatment for infertility.

However, community attitudes towards an infertile person were said to depend on the person's character and behaviour. In the case of an infertile woman, her behaviour, especially towards her in-laws, will be scrutinised. The smallest flaw could trigger rumours that the person has brought the infertility upon herself. Once the community starts gossiping, the life of an infertile person becomes very difficult. The infertile man or woman can be mistreated on any occasion by community members who do not like him or her. In the case of an infertile woman, her in-laws may also abuse her; a man would not suffer such treatment from his in-laws. It is believed that such individuals or couples bring about their own infertility by breaking societal rules and norms that could either cause physical problems or produce a supernatural punishment. Other self-inflicted infertility could be the result of promiscuity, abortion, witchcraft and sorcery. Infertile women may be suspected of being a witch themselves and

infertile men may also be accused of being involved with sorcery. These men may be suspected of having sold their semen for money to a witch or *babalawo* who used it to make a powerful charm.

Individual women in exploratory interviews had a more negative view about how communities react to infertile women than the participants in the FGDs did. An explanation for this difference may be that the individual women gave more stereotypical and extreme examples, which usually constitute more 'appealing' stories and linger in women's mind as something to be feared. They believed that infertile women are always under suspicion, and must endure harsh treatments, especially from their in-laws who often advise their son to divorce his wife or have children with another woman. One woman in an exploratory interview commented, 'Especially those women who do not have children are very envious of others who have them, they get bitter. They will do whatever they can to destroy the other women with children'. Another woman said, 'When women are infertile, people may say she is a witch. Witches have given their womb to the witches meeting. They have children, but they are not for people. Infertile women are treated as outcasts'.

When an infertile couple has tried all treatments for a long time (perhaps ten years) and still cannot have children, the community will advise them to separate and remarry in order to attempt to produce children with another partner. If the problem is assumed to be with the wife and the husband does not want to separate from her, he will be advised to take a second wife to have children for him or try to have children with an 'outside wife'. It is believed that such an action on his part may even make the first wife also able to conceive. There is a proverb to console the first wife and to advise her to rejoice when the second wife has a baby, because her own baby will come soon, '*Ori omo lo n pe omo waye*'. 'It is the head of a child that brings another child to the world'.

In case the man is suspected or known to be the cause of the couple's inability to produce a child, the FGD participants explained that the family of the wife might ask her to separate and come back to her family. If the couple does not want to separate they may decide for the wife to become impregnated by another man and the husband will pretend the baby is his own; this happens in only extremely rare cases. This has to be done in utmost secrecy, because it is not socially accepted and his family might refuse the child.

Community perceptions about infertility will probably continue as they are for some time to come, because young boys and girls generally expressed the same negative opinions about infertile men and women as adults did. Table 8.3a and 8.3b show the answers that secondary school students gave to the 'complete the sentence' questions on a woman and a man without children, in a self-administered questionnaire for the present study.

Table 8.3a. Answers of secondary school students to 'complete the sentence' question on a woman's infertility

<i>answers to the question: 'A woman without children.....'</i>	<i>N=140</i>
<i>negative emotions of the woman</i>	
Will not be happy, she will not feel well	19%
<i>negative reactions of others</i>	
She is called 'barren', <i>agan</i> in Yoruba	14%
She is abused, suffers, is treated badly (by the family of the husband)	11%
She is called a witch	8%
The husband will not love her, he will marry another (his family will force him)	8%
She is a nun	4%
<i>about meaning of her life</i>	
She has nothing in this life, she is unimportant, why did she come to this world	9%
<i>practical problems</i>	
She has no child to send anywhere, to care for her in old age, to inherit her properties, nobody to bury her	5%
<i>advice</i>	
She should pray to God	4%
<i>other answers (each mentioned just a few times)*</i>	18%
<i>Total</i>	<i>100%</i>

* Including: 'is wicked to other children', 'had a baby before and threw the child away' and 'is called *ogbanje*'.

Table 8.3b. Answers of secondary school students to 'complete the sentence' question on a man's infertility

<i>answers to the question: 'A man without children.....'</i>	<i>N=103</i>
<i>negative emotions of man</i>	
Feels sad, feels not well, is not happy	15%
<i>negative reaction of others</i>	
Is impotent, <i>okobo</i> in Yoruba, has a problem with his sexual ability, his sperm is not good	14%
A bachelor	7%
Is a monk, a reverend father	6%
<i>practical future problems</i>	
Has nobody to inherit his property, no child to bury him, nobody to rely on in future, nobody to inherit his name	13%
<i>about meaning of life</i>	
Is a nothing man, has nothing in this life	8%
<i>Advice</i>	
He should look for another wife	6%
<i>other answers (each mentioned just a few times)*</i>	31%
<i>Total</i>	<i>100%</i>

* Including: 'will be insulted', 'used his penis for money', 'has done bad things when he was young', 'is a homosexual', 'is a wizard', and 'means his wife is not attractive or sexual'.

In the eyes of Yoruba youth (there were no differences between girls and boys), the life of infertile women and men is very miserable. All believed that having no children points at an infertility problem. None of the Yoruba students suggested, as Dutch students did in a similar questionnaire, that not having children might be a deliberate choice of a person or that childlessness could be advantageous in having more time for other pursuits such as a career.³

The perceptions of infertility by community members indicate that it is considered a major problem for the people concerned, and that more often than not, infertility of a couple is attributed to the wife. Generally, there are more rules and regulations for women than for men in Yoruba society, and the behaviour of women, both married and unmarried, is scrutinised more carefully than that of men. Infertility is the worst thing that can happen to a person; an infertile person is at risk of being ostracised from society. Thus, it is no surprise that infertility is believed to be the penalty for violating societal rules. In this way, the threat of the stigma of infertility helps perpetuate dominant societal rules. It motivates individuals to comply with societal norms and refrain from dissident behaviour.

Prevalence of infertility

Demographers and health professionals can use several definitions when measuring infertility in a population. Many count women as being infertile when they have been married for at least five years and report that they have not had a live child in the five years prior to the survey. Women who are childless at the end of their reproductive years are also counted as infertile (Erickson & Brunette 1996:210-211). A problem with these studies is that they do not differentiate between voluntary child spacing and involuntary infertility. In addition, they do not take into account pregnancy wastage because of induced abortion, miscarriage or stillbirth. Moreover, they do not differentiate between primary and secondary infertility. Okonofua estimated the prevalence of involuntary infertility in Nigeria using the WHO definition of infertility. His findings suggest that about 20% of the couples in Nigeria had or have had infertility problems (Okonofua 1996b:957). Larsen (1995:140) estimates that one percent of women in Southwest Nigeria is childless due to primary or secondary infertility. (Other women may be childless because children have died after birth.) Her estimate is based on data from the 1990 Nigerian Demographic and Health Survey.⁴

The data of the present study support Okonofua's figures on involuntary infertility. Among the 652 women interviewed in the community survey, 18% were (ever) infertile. If we only consider the women who had ever been married,

23% reported having had infertility problems.⁵ At the time of the interview, 13% of the married women in the community survey reported infertility problems. The period of time during which they had been waiting to get pregnant ranged from a few months to 25 years with a mean of 4.2 years. Table 8.4 shows the number of years of infertility problems, reported by 47 women with past problems and by 71 presently infertile women in the community survey.

Table 8.4. Time period for past and present infertility problems reported by women in the community survey

<i>period of time of infertility problems</i>	<i>past infertility problems (N=47)</i>	<i>present infertility problems (N=71)</i>
Less than one year	-	8%*
1 - 2 years	38%	3%
3 - 4 years	38%	24%
5 - 7 years	19%	17%
8 - 10 years	4%	10%
11 years and more	-	8%
<i>Total**</i>	<i>100%</i>	<i>100%</i>

* Four of these six women had just married this year and have not had any pregnancy; one has two children already and visits the TBA for prevention of possible infertility problems; one had a miscarriage before her marriage and visits the church to pray for conception.

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

Table 8.4 shows that most women with past infertility problems conceived within four years of trying (76%), but that about one-quarter also conceived after a longer period. Complaints about infertility were mostly about sub-fertility. Very few Yoruba women in the present study were or would probably be (at the end of their reproductive life) actually childless because of being barren, although more women may remain childless because of secondary infertility (Table 8.5). Thus the figures on childlessness because of primary or secondary infertility may well appear to be higher than those cited by Larsen.

Table 8.5. Type of infertility presently suffered by women in the community survey, by duration of time they have been waiting to conceive

<i>period of infertility</i>	<i>barren</i>	<i>childless</i>	<i>sub-fertile</i>	<i>N</i>
Less than one year	4	1	1	6
1 - 2 years	3	9	11	23
3 - 4 years	1	1	15	17
5 - 7 years	0	3	9	12
8 - 10 years	0	2	5	7
11 years and more	0	2	4	6
<i>All</i>	<i>8 (11%)</i>	<i>18 (25%)</i>	<i>45 (63%)</i>	<i>71 (100%)</i>

Table 8.5 indicates that of the 71 community women who reported infertility problems at the time of the survey, 11% were barren, 25% were childless and 63% were sub-fertile. However, the duration of time during which women reported being infertile may qualify the rather high figures for (reported) barrenness. The four women who had tried to conceive for the first time for less than a year will most probably conceive, as well as the three women who had tried for one or two years. The woman who had tried to conceive for three years was only 23 years old and still had a good chance of becoming pregnant.⁶ Concerning the 18 childless (but not barren) women who complained of infertility, the most common outcome of their previous pregnancies was one or more miscarriages or children who died. Only two of these childless community women reported that they had had an abortion. The number of children the sub-fertile community women had who complained of present infertility ranged from 1 to 6, with a mean of 2.3 children per woman.⁷ In half the cases of women who had more than four living children and still wanted another child, they had a new husband and wanted a child from him. One woman with six children in a village in Epe who declared herself infertile expressed a traditional reason for having many children: She needed more hands to help on the farm.

The 69 women in the infertility survey who were clients of public hospitals and TBAs seemed to have more serious infertility problems than the women in the community survey who complained of infertility. Table 8.6 shows that more of the infertility clients did not yet have children; 15% were barren, 49% were childless and 36% were sub-fertile.

Table 8.6. Type of infertility of women in the infertility survey, by duration of time they have been waiting to conceive

<i>period of infertility</i>	<i>barren</i>	<i>childless</i>	<i>sub-fertile</i>	<i>N</i>
Less than one year	2	2	2	6
1 - 2 years	2	13	13	28
3 - 4 years	2	12	7	21
5 - 7 years	3	4	1	8
More than 7 years	1	3	2	6
<i>All</i>	<i>10 (15%)</i>	<i>34 (49%)</i>	<i>25 (36%)</i>	<i>69 (100%)</i>

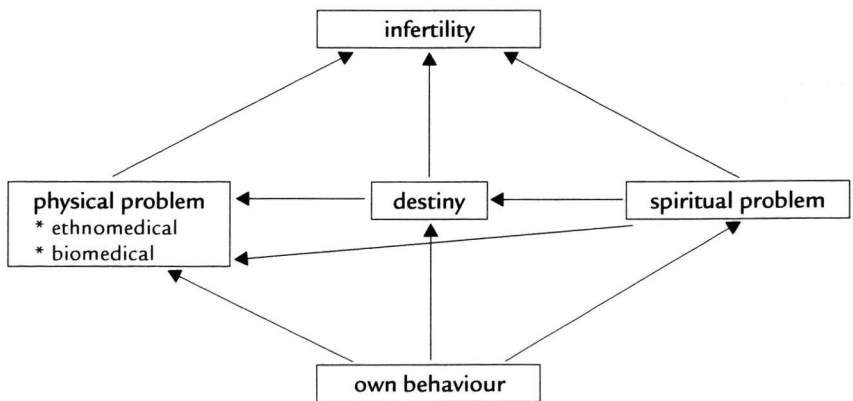
The barren and childless women in the infertility survey (in Table 8.6) have had their infertility problems longer than the women in the community survey (in Table 8.5). The number of children the sub-fertile women whom we interviewed in the infertility clinics have had ranged from 1 to 6, with a mean of 2.4 children per woman, and was about the same as the number of children infertile women in the community have had. Four of the sub-fertile women had

children from their first husband only. The 34 childless women interviewed in the infertility clinics had had between 1 and 5 pregnancies that they lost through induced abortion, miscarriage, ectopic pregnancy, stillbirth or death of the child after birth. The prevalence of abortion among the 34 childless women was high; 19 women had had at least one abortion. In a later section of this chapter I will discuss the rate of infertility problems, which were probably caused by induced abortion, but first I will turn to explanations for infertility

Looking for a cause

Attempting to explain unusual events and undesirable occurrences is part of human nature; infertile women also try to look for the causes of this unwanted problem. Yoruba believe in the physical causes of infertility used by biomedical doctors, such as hormonal imbalance, blocked tubes due to infection or an incompetent cervix.⁸ However, they also have ethnomedical and spiritual explanations of infertility, which are not recognised by biomedicine. These more traditional explanations are still common, but they have often been blended with biomedical ideas (see below). Causes may be interrelated; for example there may be an underlying spiritual force behind a (biomedical or ethnomedical) physical problem that causes infertility. Problems may arrive without any underlying reason, but may also be related to a person's behaviour. Figure 8.1 pictures the categories of causes of infertility and their interrelationships, as deduced from the explanations of TBAs, other ethnomedical healers and community members who were participants in FGDs.

Figure 8.1. Causes of infertility as perceived by Yoruba



The seminars with TBAs proved particularly illuminating about the many possible traditional causes of infertility. TBAs have comprehensive infertility aetiologies and could explicate how they looked for the signs and symptoms of these, which then influence their treatment (see also Koster-Oyekan 1999:15-19). For the purpose of this book, I limit myself to a summary of the main causes, some of which were already mentioned when discussing the community opinions about infertility, but are elaborated here.

A common ethnomedical cause of infertility is *eda*, when too much sperm is believed to flow out of the vagina after intercourse. This may be either directly after intercourse, when the woman is still lying down, called *eda idubule* (literally: *eda* when lying down), when she stands up, or after some time, even after days, *eda iduro* or *eda dide* (literally: *eda* when standing up). TBAs said that there is always some *eda*, because not all the sperm remains in the woman's body. However, it becomes a problem when too much flows out. Another major ethnomedical cause of infertility is various types of worms, *aran*, which either prevent conception or cause miscarriage. The most common type of worms is *aran giniša*, which is believed to be in every woman's womb and is necessary for pregnancy.⁹ When *aran giniša* become excessive or aggressive, they can cause miscarriage. The notion that something 'normal' may become a problem when it becomes excessive is common, as seen with the third main cause of infertility, which is *iju*, fibroid in the uterus. A fibroid that is too big is believed to prevent conception or cause miscarriage, whereas every woman should have a small intrauterine fibroid, which is needed for conception.¹⁰ *Eda*, *iju* and *aran giniša* may become abnormal without a clear reason, because of a spiritual problem or immoral behaviour of the woman. Yoruba acknowledge that men can also have ethnomedical problems that cause infertility: watery sperm, internal heat, impotence or *aran eše*, which is a worm in the leg. TBAs said they would normally look for ethnomedical causes first and by their treatments follow a trial-and-error approach to diagnosis. For example, if a woman gets pregnant after a treatment for *eda*, the TBA would conclude that *eda* was the cause of infertility.

TBAs said they would start suspecting spiritual causes for infertility if all their treatments of possible ethnomedical causes prove ineffective, when some physical signs of spiritual problems (such as specific rashes) abound or when the oracle has indicated a spiritual cause. Spiritual causes are mainly related to *juju*, or magic, which is generally a very strong belief in Yoruba society. Jealous co-wives, dumped lovers, wicked human beings, evil spirits, annoyed ancestors, sorcerers or witches may all use *juju* to cause infertility. Sometimes an infertile woman may be accused of being a witch or evil spirit herself. Her infertility is considered proof of her status as a witch or evil spirit because witches and evil spirits are said not to have any children in this world, but only in the spirit

world. Another spiritual ground for infertility is having sexual affairs with spirits. A single or married woman may have a spirit husband, *ọkọ ọrun*, who visits her in her dreams and has sex with her.¹¹ A man can have sex with several spirits (men are also allowed to be polygynous in their dreams). This too causes him not to be able to impregnate his earthly wife.

Besides the ethnomedical and spiritual causes of infertility, Yoruba believe in destiny (fate) as the intention of God. It could be a person's or a couples' destiny to be childless. In the case of a couple, their blood is said to be 'incompatible'.¹² However, the man and woman could have children with another partner. Although one is believed to have pledged one's destiny at birth, this may still be affected by outside influences or one's behaviour. In keeping with their optimistic approach to life, Yoruba women with infertility problems accept that they were *really* destined to not have children only after they reach menopause. Before that time, they try to influence their suspected destiny in various ways and always continue to believe in miracles.

Individual's dissident behaviour could cause infertility, as was briefly indicated earlier in this chapter. Most non-conforming behaviour relates to the violation of dominant rules about sexual behaviour, such as having multiple sexual partners, being exceptionally young at first intercourse, having extramarital affairs, inducing abortion and using modern contraception. Such behaviour may cause physical problems, both ethnomedical and biomedical, or bring about spiritual causes for infertility. Induced abortion is considered a major transgression in Yoruba society.

The TBAs explained the different ways in which induced abortion might cause infertility. TBAs said that too many D&Cs might weaken a woman's cervix or uterus and thus result in habitual miscarriages, just as biomedical health workers claim. Abortion by D&C, insertion of other instruments and substances or swallowing drugs could damage the womb, which makes the uterus unfit to carry a baby or makes it unable to conceive. TBAs also perceived severe and prolonged bleeding after abortion as a risk to future fertility. In addition to problems acknowledged by biomedicine, TBAs recognised ethnomedical problems resulting from abortion. Blood remaining in the womb after the abortion might clot and cause a fibroid to increase in size and become too big. Weakening of the cervix due to many D&Cs may result in too much sperm to flow out after intercourse (*eda*), which prevents fertilisation. Abortion could also cause infertility problems of a spiritual nature. It may affect the outcome of the woman's destiny, for no one knows the number of children one is destined to have, and by aborting one or more pregnancies, a woman may abort the only children allotted to her. Abortion might also lead to the wrath of ancestors or family *oriṣa*,

especially in families where an explicit taboo on abortion exists; an abortion may cause them to punish the woman with infertility.³

TBAs, like most Yoruba, are ambivalent about modern contraception. They explained how the use of it might cause infertility, which indicated some knowledge of biomedicine. TBAs said that modern contraceptives could 'spoil' something inside the womb, cause a fibroid to grow or irreversibly disturb the hormonal and menstrual cycle. Oral contraceptive pills (OCP) and injectables were especially believed to cause infertility because they 'work with the blood'. However, some traditional contraceptives could also cause infertility, for instance if the knowledge of the antidote for a semi-permanent contraceptive such as *aseje* (herbal soup) becomes lost. The woman in the history below believed this to be the cause of her infertility problems.

A 31 year-old, well-off Christian businesswoman, who had two children from her first marriage who have both died, is now in her second marriage. She has had no abortions or miscarriages: "I have used contraception, both traditional and orthodox. I think it is the traditional that is affecting me now. After my second child my mother-in-law [mother of her first husband] bought me some *aseje*. She told me that it was for family planning and that she had used it herself. Some two years later my husband took another wife and my first child died. I moved out from my husband's house and was living alone. When my second child died some eleven months later I decided to remarry. [She said her first child died 'just like that', while her second child was sick first.] Ever since, I have been going from one hospital to the other and from one traditional herbalist to the other, just to get pregnant again. I think the *aseje* that my first mother-in-law gave me makes me not able to get pregnant till this time. I remarried one year and eight months ago. My first mother-in-law is very sick now and she is the only one who knows what I can use to reverse the situation. [The woman started crying and we had to stop the interview.]

Women and men are also believed to be able to bring infertility upon themselves when they violate family taboos (other than those related to abortion, such as not eating certain foods) or covenants, and when they offend family ancestors and *oriṣa* (deities) or any other person, including previous sexual partners. Promiscuity carries a high risk of contracting *atpsi* (gonorrhoea), which causes the body to become 'too hot'. This in turn results in ethnomedical problems causing infertility: *eda* for the woman, or watery sperm for the man.

Based on the history of the infertility clients they treat, the TBAs involved in the present study said that the ethnomedical causes of *eda*, *aran giniṣa* and fibroids are the main causes of infertility problems. The next most common cause of infertility is that which results from the person's previous behaviour and is

mainly due to the physical complications of induced abortion. They believed that spiritual causes and *juju* by jealous and evil persons are less common, and that only very few women and men are destined not to have any children. TBAs acknowledged that the husband might be responsible for a couple's infertility, but thought that this was rare. They said they would always examine the wife first and only if no cause could be found, would they test her husband.

When we asked 113 women with present and past infertility problems in the ANC survey and the community survey what *they* thought the cause of their infertility was, most women attributed it to physical causes, of which more were ethnomedical (especially *aran giniṣa* and *ẹda*) than biomedical. Only a few women (13% of all) blamed themselves for their infertility; the 'present infertility' clients because they had an induced abortion and the women with 'past infertility' problems because they had used modern contraception. Some women who feared that their abortion might be the cause of their present infertility said things like 'probably God is annoyed with me'. However, a large group (25% of all) said they did not know the cause of their infertility, perhaps because they suspect they themselves are to blame, and do not want to admit it. Putting thoughts into words makes them become more real.¹⁴

Coping with infertility

Being infertile or facing the threat of infertility in Yoruba society is stressful; those who are suffering such a plight will try to resolve the situation one way or another. In Yoruba society, the main strategies for coping with infertility are more those of problem-solving than emotion-focused coping. Very few Yoruba women and men will resort to emotion-focused coping by deciding voluntarily to live without children and to look for other ways of leading a fulfilling life. Infertility is an undesirable status and infertile women and men will take actions intended to avoid a childless life and the stigma of infertility. Some take traditional preventive treatments even before there is an actual problem. Once there clearly is a problem, both women and men will try all sorts of infertility treatments. If all treatments seem to fail, Yoruba will try to secure having children in another way.

Prevention of infertility

The mere *threat* of infertility is the reason that many women visit a traditional provider for prevention of possible infertility. After just a few months of trying to conceive, women often visit the *ọlomo wewe* to get herbal drinks that prevent

anything that *could* go wrong from happening (see also Maclean 1982:168, for Yoruba in Oyo State). Many women had also attempted to prevent (secondary) infertility by going for a D&C in a private hospital of their own initiative, after a miscarriage or abortion, to clean the uterus of all possible dirt that could cause problems with conceiving in future.¹⁵ Yoruba call this *fọ inu*, which literally means 'to wash the inside'.

Many pregnant Yoruba women interviewed in the present study were taking preventive measures against the threat of miscarriage by evil forces that may try to tamper with their pregnancy. Taking preventive measures against miscarriage is called *ideyun* or *oyun dide* (literally: to tie the pregnancy), also described by Adetunji for Yoruba in Ondo State (1996:1564). Women said they tried not to walk outside in the hot sun between 12 PM and 3 PM and at night between 12 AM and 6 AM, when evil spirits are out. These spirits could cause miscarriages; they could also cause the baby to be malformed or be possessed by an evil spirit. As mentioned before, many pregnant women carried a safety pin and a small stone in their *rappa*; these are believed to protect them and their unborn babies from those spirits. They also wear an *oruka*, a medicinal ring prepared by the TBA, to prevent miscarriage. TBAs have several ways to prevent a pregnancy from 'coming down' and each TBA has his or her own methods. In an exploratory interview, one woman reported that the TBA had rubbed an egg upward over her abdomen when she was two months' pregnant. The TBA had kept this egg somewhere until one week before the expected delivery, when he had rubbed it downwards over her abdomen, to free the foetus. She delivered safely one week later.

Infertility treatment

Given the fact that Yoruba perceive infertility to be a very serious problem and given the entrepreneurial character of Yoruba society, it is not surprising that many different treatments for infertility are offered: biomedical, ethnomedical and spiritual. In private and public biomedical hospitals and clinics, women can have a scan made of their uterus, have hormonal levels tested or have surgery to remove fibroids or open blocked ovarian tubes. Women are treated for infertility with oral medicines and injections. None of the women with infertility problems involved in the present study had in-vitro/vivo fertilisation (IVF) treatment, and I am not sure whether these services are even provided in Lagos State. If they are, they are rare and will be extremely expensive.

The TBAs give both ethnomedical and spiritual treatments for infertility. Their medicines include *aseje* (medicinal soup), *agbo* (herbal medicinal tea) and *ebu* (black medicinal herbal powder) or they may make *gbere* (incisions into

which medicine is rubbed). Some of the TBAs said they sometimes sent their infertile clients to the hospital for investigations. From the results of these hospital tests, the TBAs would deduce which treatments to prescribe.

Woli (prophets of spiritual churches) and *babalawo* (Ifa priests) treat spiritual causes of infertility. The *babalawo* uses divination to find out the cause of the infertility. A *babalawo* explained that he uses cowry shells, kola nuts or any other divination instrument to consult the Ifa oracle. The oracle may tell him that certain deities or ancestors are annoyed with the infertile woman, man or family because they have not fulfilled their ceremonial obligations or did not observe certain taboos. The oracle would then indicate which sacrifices to make to appease the deities or ancestors. The oracle may also indicate that witches or other *babalawo* have put a spell on the woman. In that case, the *babalawo* may cure the woman by using his own spiritual power in a ceremony to undo the spell. The woman will have to buy ingredients, such as kola nuts, gin, a cock and a goat for the ceremony and pay him a fee.

Spiritual churches, including *Aladura* and Pentecostal churches hold special weekly sessions for women who have problems conceiving. An attendant of the Cherubim and Seraphim church (one of the *Aladura* churches) told us about those sessions for *agan*, barren women in his church.

On Tuesdays, the *agan* come to the church with water and fruits. Fruits are important, because fruits grow wherever you throw them [most Yoruba live in a tropical climate with fertile soil, where indeed everything germinates]. The fruits to bring are bananas and oranges. No papaw, because these may be possessed by evil power. Many women come to this church after having visited several healers. The *woli* [priest] will tell them what to do: fasting, praying, take a sip from the mixture of perfume and olive oil that he has prayed over. When women do this a few times they will conceive when sleeping with their husband. Women will also bathe in the stream. Sometimes there are special prayer nights from 12 o'clock midnight to 5 o'clock in the morning to frighten witches and *ogbanje* [evil spirits] who at this time are around. The *woli* may point to the *agan* and say that she is possessed by *ogbanje*, causing her infertility. The woman should be ready to have treatment to get the *ogbanje* out. The *woli* may also say that she has spoilt her womb by sleeping with too many men, or has done abortions. Women who come for treatment should promise something to the church when they do get pregnant. This could even be a car.

More than four-fifths of women who reported infertility problems interviewed in the community and ANC surveys sought treatment for it.¹⁶ Only a minority did not, and hoped the problems would be solved naturally. The choice for a provider appeared to depend on several factors related to the believed cause for

infertility, the availability, cost and accessibility of the providers. The interviews with women in the community survey who had infertility problems showed the important role of TBAs in infertility treatments (see Table 8.7).¹⁷

Table 8.7. Infertile women's utilisation of infertility treatment providers in the community survey, by location (multiple response)

<i>provider</i>	<i>Lagos (N=41)</i>	<i>Epe (N=54)</i>	<i>all (N=95)</i>
TBA	49%	72%	62%
Biomedical provider	69%	33%	48%
Public health institution	(32%)	(24%)	(27%)
Private health institution	(37%)	(9%)	(21%)
Church*	2%	19%	19%
<i>Babalawo</i>	12%	6%	8%
Other**	5%	4%	4%

* 12 went to an Aladura church, mostly Cherubim & Seraphim, while 6 went to a Pentecostal church

** 'Others' were an Alfa in the mosque, a neighbour who gave herbs and a drug peddler

In Epe, considerably more women with infertility problems went to a TBA than in Lagos, where the majority of women interviewed went to biomedical providers, especially to private clinics and hospitals. This may be a matter of preference, but also of availability. In all areas of Lagos town there are many private biomedical institutions, whereas in Epe LGA there are very few; all but one are concentrated in the LGA headquarter. However, women do not stick to one provider in their quest for infertility treatment. They try several and hope that one will work. More than one-third of the 95 women in the community survey who sought treatment for infertility problems consulted more than one provider. Some had even gone to three or even four different providers for infertility treatment at the time we interviewed them.

That women shop around for services was also illustrated by the experiences of women of the infertility survey interviewed in public gynae clinics and TBA clinics. Of the 53 infertility clients who were interviewed in public hospitals, 55% had visited another service provider, while 69% of the 16 women whom we interviewed at TBA clinics had gone to another service provider. Most used the different providers consecutively, but some used them at the same time (23% of the hospital informants and 16% of the infertility clients in TBA clinics). Women attended the church infertility services throughout the course of their treatments at biomedical and ethnomedical healers, because, as they said, 'In the end it is always God who gives children'. They only give up seeking infertility treatments when they become pregnant or reach menopause.

A 49 year-old Christian married woman of high educational, social and economic status shared her struggle to conceive: "I married when I was 21 years old. I tried for 23 years to get pregnant. I went to many doctors, in Nigeria, UK and the US who made my husband and me have all sort of tests. I had my fallopian tubes unblocked by a doctor in Ibadan [city about two-hours-drive from Lagos]. I also went to two traditional healers. My friends who were concerned had advised me to consult them and I did for two years. I was willing to try anything. I was around 34 years old then. I was not impressed with the traditional healers. They would ask all sorts of questions, they consulted their oracle and gave me medication for what they assumed to be the problem [trial-and-error treatment]. They did not do any physical examinations. My husband and I decided to really focus our attention on getting children. Therefore I gave up my job as a secretary and went to the US. Finally I had a huge fibroid removed by D&C and I got pregnant. I got a baby girl when I was 44."

By going to various providers, a woman optimises her chance of solving her problem. However, it may also be confusing. Different providers often give divergent reasons for the problems. The church may say the infertile woman is possessed by evil forces and needs special ceremonies to get rid of them. The TBA may give her *agbo* and *ebu* (black powder) against *aran giniša*. Meanwhile, the doctor says she has a hormonal imbalance and needs to buy medicines to correct this.

A 32 year-old Muslim trader with a secondary school certificate, married ten years ago as the second wife of her husband who now has three wives. She is five months pregnant with her first child: "To me, I now believe that God was just not ready to give me a child yet. I went to a private hospital, but was not told what was wrong with me, because I did not co-operate with the hospital staff. I did not want to do a certain test [hysterosalpinogogram] because I thought it might destroy my womb. In the church I met various false prophets who told me different things. Some said that I was bewitched, that it was due to the sins I had committed, some said it was the first wife of my husband who was behind it, and some thought that my mother-in-law was the cause. Some even said that my own mother was a witch who was after me. The *babalawo* said my infertility was due to *eda*, and gave me different types of concoctions and asked me to perform several rituals, which I did. The TBA did not really say what was the cause, but gave me many local concoctions to drink."

Biomedical doctors know that their infertility patients also go to spiritual healers and TBAs, especially for treatment of infertility that they believe is caused by spiritual problems. Some doctors whom we interviewed for the present study

said they believed in these causes, but that they do not have medicines to treat them. The following history of an infertile woman also indicated that the nurse who attended her believed in causes of infertility other than biomedical ones.

A married businesswoman of 32 years with three children: "... I had three children before I did coil in 1994. I removed it in June 1997 and ever since [one-and-a-half years] I have not been pregnant. I went back to the same hospital where they did the coil and complained that since I removed it I have not been able to get pregnant. The nurse was shouting to me on top of her voice that I should go and check my family. That maybe they are the ones that cause my infertility and that I should not spoil her job."

Yet, some of the doctors of the public hospital were fiercely *against* everything traditional health-care providers do. A doctor in the gynae clinic told me, 'They do too much harm. Just last week we got a woman who had been treated for infertility by a traditional healer. She had to rub black powder in her vagina. Her vagina was all scarred, as if she was burned.' Doctors of the public hospital pointed out how private hospitals and clinics exploit the situation. These private 'infertility clinics' advertise in buses by educators giving talks and handing out flyers, about how they can solve infertility problems using scans to find the underlying problems. However, public service doctors believed that in many of these private hospitals unqualified personnel (quacks) act as doctors and mislead infertile clients.

Evidently, provider choice is related to what women (and their relatives) believe to be the cause of infertility. If women believed the cause was spiritual, they did not go to a biomedical hospital first. However, they would often let their choice be directed by what they had heard about providers from people they know, especially if they had no idea about the cause. Most providers appeared to be publicised by word of mouth. The 69 infertility clients in the infertility survey had travelled long distances to consult certain providers whose treatments they had heard about as being successful. Female friends were the most important source of information, particularly in the cases of women who went to the hospital. Female relatives (mostly in-laws) also played a relatively big role in the choice of a provider, especially in terms of choice of TBA. Only three women went to a provider of their own initiative, all of these women went to the hospital. Husbands seem to play only a minor role in decision-making, as just one woman had been directed by her husband, to a TBA (see Table 8.8).

Table 8.8. Infertility clients' source of information about their present provider

source of information	hospital clients (N=53)	TBA clients (N=16)	all (N=69)
Female friend	51%	44%	49%
Relative *	15%	25%	17%
Neighbour/people around	15%	13%	15%
Colleague	6%	1 ⁿ	6%
Nobody (went alone)	6%	-	4%
Husband	-	1 ⁿ	1 ⁿ
Others **	8%	1 ⁿ	7%
All***	100%	100%	100%

Source: infertility survey

* All were female, including sister (in-law), auntie, mother (in-law), and first wife of the husband

** Men and women including husband's friend, family friend, retired matron from the hospital and housemaid

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

ⁿ Numbers are given instead of percentages if the figure is only 1

Decision-making also depends on the cost of treatment and the money available to pay for it. Several women mentioned spontaneously that they had to stop certain treatments because of the cost. Analysis of what women reported to have spent on their treatments indicates that in general, clients spent less money in TBA clinics than in biomedical hospitals, either private or government owned.

Other wives

If, after a few years of marriage, their wives have not conceived, the most common and socially accepted strategy that men use to secure children is to marry a second wife. In Yoruba tradition, a man can marry as many wives as he can afford. Those marriages cannot be contracted in the church or at the Registry, but only through a traditional ceremony or in the mosque. In the present study, several women in polygynous marriages reported that their husbands had married another wife when they were not able to conceive or give him enough children.

A 27 year-old Muslim woman has not been pregnant since she married five years ago: "I have been trying to get pregnant for five years. I went to the *olomo wewe* for two years who gave me *agbo*, without telling me what the cause of my infertility was. He just said I would conceive after taking the *agbo*. I stopped because there was no result. Then I went to the maternity hospital [where this interview took place]. I have been coming here for three years already. They did various tests, urine test, scan, X-ray and they tested my hormonal levels, but they did not find anything wrong with me. My husband got impatient

after three years and took a second wife. My in-laws do not recognise me anymore as a wife. They even do not want to eat my food anymore. I believe that the cause for my infertility is that someone is really against me, but I would not know who that person is."

The *threat* of one's husband marrying another wife because no children are produced is always there. Ideally the wife should understand and respect this, but I did not find any woman who was happy with her husband's decision.

A 38 year-old married Christian schoolteacher who has (only) one 15 year-old son anticipated what her husband would do if she did not conceive again: "I like to live with my husband under one roof. It depends on the situation how women in a polygynous home live together. If they are jealous, they can make life very difficult for each other. I originate from a polygynous household and there was a lot of trouble between wives. For me, I expect that my husband will come home one day with another woman, especially because I have this problem of secondary infertility. We have never discussed it, my husband and I, but I will not take it when he comes home with another woman. I will move out as soon as the other moves in."

Men who want children do not necessarily have to marry the mothers of these children. As explained earlier, in Yoruba tradition, children born outside of marriage are accepted into the patrilineage when the father acknowledges the children as his. They are then granted a legal status. Several women with infertility problems whom we interviewed said their husbands fathered a child from an extramarital affair. They had to accept the situation and understand the importance of the perpetuation of the patrilineage.

A 49 year-old Christian woman with a post-secondary education and high social status married when she was 21 and waited for 23 years for her first child. She told me: "All this time [that she tried to conceive], everybody was very sympathetic, my husband, family and in-laws. My husband and I did not want to divorce because of our problem. My husband had two daughters with other women that I took care of from when they were around ten years old [they are in their early twenties now]. I was just confronted with the situation; it was not a joint decision. I never wanted to be involved in the background of the affair of my husband with the mothers of these children, or their feelings about the situation that their daughters had to live with the father."

Cuckolds

A woman who wants to stay with her infertile husband because of love or because of money (either he is rich and gives her money, or she and her relatives have no money to pay back the bridewealth upon divorce), has the option of getting pregnant from another man. She would have to do so in utmost secrecy, because her husband and his family would not accept a child that biologically (and thus spiritually) does not belong to their patrilineage. So, it is no surprise that in this study I could never verify from firsthand experience that a woman became pregnant from a man other than her infertile husband. However, I recorded stories told by some doctors about their clients and by some women during the in-depth interviews who had heard such stories from a doctor who was their friend.

A doctor in the gynae clinic of a public hospital recounted: "I once had a client who was a very rich Alhadji [a title for a Muslim who has been for pilgrimage to Mecca]. He came to my clinic with his fourth young wife of 19 years old, worried that she had not conceived yet. His three other wives had children already. I performed tests and found that his sperm was not fertile. The man did not believe me when I told him this because his other wives already had children for him. The new wife said that it probably was from an illness that he had a few months ago. However, I knew that this was not true and I privately advised the wife 'to do her own', because this infertility of the man was not from the disease and would not go. I told her to go and talk to the other wives, but did not go into detail. After some time the woman came back pregnant – from her former boyfriend, as she admitted to me." [The doctor did not know whether the woman had actually consulted the other wives or had made arrangements of her own initiative.]

I never heard informants suggest that in-laws could make arrangements for their daughter-in-law to get pregnant secretly from another man for their son, as described for example by Mgalla & Boerma (2001:198) for Sukuma of Tanzania.

Parenting other people's children

Adoption is not common among Yoruba because of the unknown background of the child. A child remains tied to the patrilineage of his own father; every child has relatives, alive and dead. The child's ancestors may interfere with his or her life, and by extension, the lives of the family who adopt the child. A member of the adopted child's living extended family may come to claim him or her at any time. There will also be serious problems with inheritance, because

the blood relations of the adoptive parents will always fight against an adopted child inheriting anything. Moreover, in the realm of ancestors and spirits, the adopted child has no role to play in the patrilineage of its foster parents, because there is no blood relationship.

A 49 years-old Christian married woman who had infertility problems until she was 43 made the Yoruba viewpoint on adoption clear: "I had the daughter of my sister staying with us already from baby stage. My sister died in [another] childbirth, when the girl was two years old. I just recently told the girl that I was not her mother, but the sister of her mother. I have never considered adopting the girl, because that is not really accepted among the Yoruba. I had earlier suggested to my husband to adopt a baby from the motherless babies home, but he could not take this serious. Not many babies are left orphaned without being taken care of by a relative - in the whole of Lagos there are only two orphanages."

Fostering the children of a relative is more common, as in the case of the woman above, but in this study we did not verify whether this practice is more common among couples having infertility problems. Some parents send their children to live temporarily with more affluent relatives, have children stay with grandparents who need their assistance and or send children to relatives when they themselves are not around. Fostering often occurs to promote schooling and general education opportunities for the child.

A 38 years-old schoolteacher in an exploratory interview: "Infertile women may take care of the children of a close relative and may be called by that name, i.e. Iya Wale [mother of Wale]. The children will be allowed to visit their biological parents. The burial of such a woman may be grand, to show that she was well taken care of during her life, and that the persons arranging the burial will be rewarded. The saying goes, 'When the dead person is happy, things will go well for you'."

The wild stories about the trade in babies by nurses in hospitals illustrate the desperation of infertile couples to obtain a child by any means possible. A 40 year-old secondary schoolteacher related what she had heard:

There was a story in the news some time ago about what infertile couples can do. In a certain hospital there was a market [trade] in newborn babies. The nurse would say to the woman who just delivered that her child had died. Some people do not bother to ask for the dead body, because they know that they then have to take it home and find a place to bury it. The baby is then sold for a big amount of money. Therefore, especially older women who get pregnant should let themselves be seen when pregnant, or else people may believe they have stolen the child.

I found that this advice is taken seriously in first hand observation. A 49 year-old woman finally got pregnant after receiving fertility treatment in America. When she got back to Nigeria, photographs of her uncovered seven-months-pregnant belly were shown to everyone visiting her and her new-born baby. A woman whose fertility would be beyond suspicion would never do this.

Divorce and remarrying

Divorcing the first spouse and marrying another is a fairly accepted coping mechanism in Yoruba society if a couple cannot conceive. This can be initiated either by the husband or by the wife. The primary aim of a marriage is to have children and although marriage is supposed to be for life, the reality of not being able to conceive overrules morals and vows of life-long marriages for 'better, for worse' and it may even overrule economic considerations. The bride-wealth is a deterrent to divorce for both the husband and the wife. If a husband divorces his wife, he loses the bridewealth he paid for her. If a woman seeks a divorce she will have to pay back the bridewealth. Therefore, a man will not usually want to divorce his infertile wife, but rather marries a second wife, while an infertile woman will be more inclined to divorce if she has the money.¹⁸

Reactions of husbands and in-laws

By analysing the experiences of the 69 women in the infertility survey with the reactions of their husbands and in-laws to their infertility, it can be determined if the stigma of infertility is indeed based on reality as experienced by infertile women. Their husbands' and in-laws' reactions ranged from supportive and calm to very anxious and verbally abusive (Table 8.9).

Table 8.9. Reported reaction of husband and in-laws to infertility of 69 women in the infertility survey

<i>reaction</i>	<i>husbands</i>	<i>in-laws</i>
Relatively positive	(68%)	(75%)
Understanding/supportive/consoling	36%	26%
Calm/does not bother her/no problem	32%	49%
Relatively negative	(32%)	(25%)
Sad and worried, feels bad (husband), cool for now, but the threat is there (in-laws)	13%	3%
Angry, bitter, annoyed (husband), stress too much, push the husband to take another wife (in-laws)	19%	22%
<i>Total</i>	<i>100%</i>	<i>100%</i>

Most husbands (68%) were said to be relatively positive. Supportive and understanding husbands sympathised with their wives and made them feel that they were facing their infertility problem together. Such husbands may take their wives to treatment providers. Husbands were also reported to be calm and not bothersome to the woman. That a husband was just 'not bothering' was not always easy for the woman who was anxious to conceive; she needed more support. A woman who had already waited for seven years to conceive said, 'I do not really know my husband's mind, but all the same he is not disturbing me'. About one-third of the husbands, however, had a negative reaction. Some men were very anxious and worried, and thought mostly of the consequences of the infertility for themselves; they were angry and annoyed with their wives.

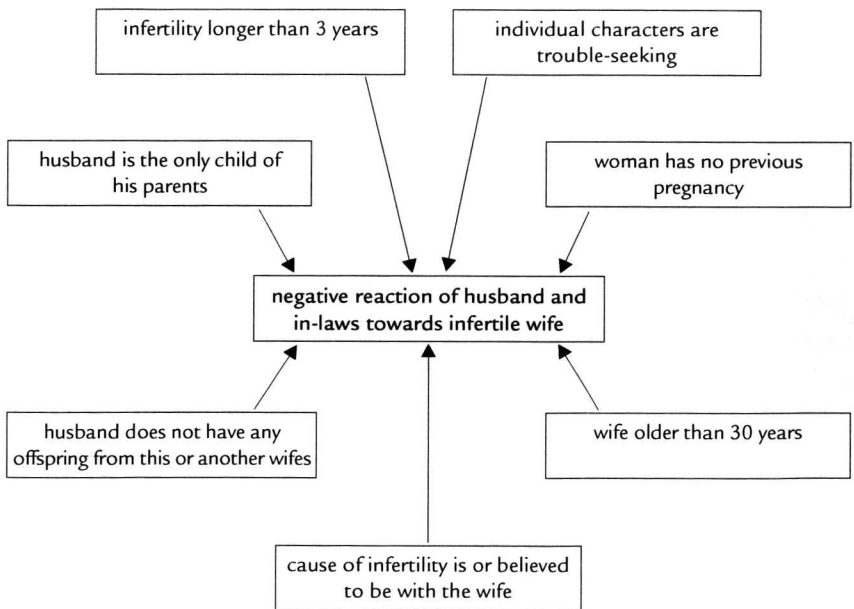
Most infertile women interviewed had in-laws who were likewise supportive or at least did not bother them. Some women explained that their in-laws usually did not interfere with the couple's personal affairs, while others said that their in-laws thought that the couple did not want children yet. Some women felt that their in-laws were still nice to them, but they expected them to change for the worse if they did not conceive soon. Some in-laws verbally abused their infertile daughter-in-law or tried to convince their son to take another wife.

Given these data, the perception that *all* infertile women are treated badly and are stigmatised does not correspond with reality. Still about one-fifth of the women with infertility problems had to endure neglect, verbal abuse and anger, slightly more frequently from their in-laws than from their husbands. The most common threats, also put into practice in several cases, were that of the husband taking another wife or of divorce.¹⁹

A 25 year-old barren housewife who married this year as the second wife of her husband: "I have wanted to get pregnant for four months and visited the *olomo wewe*. My auntie brought me to him. According to the *olomo wewe* I have *aran ginisa*. My husband is angry with me for not getting pregnant and threatens to divorce me. I learned that his first wife waited for four years before she had her first issue [child]. Her second child is five months old. My husband usually makes comments like that he cannot continue to harbour a male dog (*oko aja*) under his roof. If I ask for money from him, he is always complaining. For instance, instead of giving me 50 naira to come to the clinic (20 naira for medicines and 30 naira for transport), he only gives me 20 naira. My in-laws, especially my mother-in-law is really disturbing me. She is always passing nasty comments like *nkọ ti ama ri e si niye* (that is all you know) and *omọ nkọkọ ju yi l'ọ* (you know nothing else than that) each time I ask for money from my husband." [It was striking that the woman was even complaining about her mother-in-law. It is demonstrative of how bitter she felt; normally Yoruba would not openly abuse family in such way.]

Being supportive or abusive towards a wife who is suspected to be infertile will partly depend on the characters of the individuals involved (the wife, her husband and the in-laws) and on their relationships to each other. However, from the analysis of the reactions towards the 69 infertile women of the infertility survey, some factors that contribute to negative reactions of husbands and in-laws can be identified, and are summarised in Figure 8.2. Illustrations later in this section will indicate that individual character variables may overrule all other factors (as they probably did in the case of the woman above).

Figure 8.2. Factors contributing to negative reactions of husband and in-laws on infertility of wife



The husband and in-laws were both negative towards a wife who could not produce children when she had not borne any living children for the family for a long period, usually a mean of five years, and she was of an advanced age, e.g. over 30 years old. Some of the women had to endure very harsh treatments by their husbands and in-laws.

A 27 years-old barren Pentecostal teacher who has been married for five years: "My husband is not happy and threatens to take another wife. In order to prove that nothing was wrong with him, he impregnated a 15 year-old girl last year. The girl never had the baby, because her senior sister took her to a private hospital for D&C when she got to know about the pregnancy. My family in-law is also threatening me. They all believe that the problem is from me. I have been to a private hospital for one year, but there it was too expensive, and after that I also went to an *olomo uwu* for one year. When there was no result I stopped and I am since two years under treatment in the general hospital."

A 27 year-old Pentecostal woman who has been married for seven years, has had two abortions before she marriage and has had two miscarriages this year: "My husband was very worried and understanding initially before he changed his mind and became uncaring. He now has four kids from two different women, but he is not married to them. My family in-law pushed my husband to impregnate women outside."

Husbands and in-laws were more positive towards the infertile wife in situations where the husband already had children, or when they believed that there was still a good chance that the woman would conceive.

A 38 year-old Muslim trader is the second wife of her second husband whom she married two years ago; she had one abortion before her first marriage, and one miscarriage during her first marriage: "I have been waiting for ten years to have a baby. I only had a miscarriage some four years ago. My new husband is very sympathetic with me; he has been taking me to different TBAs and even accompanied me here to the general hospital just last week. My former husband and his family disturbed me a lot and that is why I finally left him. He married another wife after some years. I feel that my new husband and in-laws are not disturbing me, because my co-wife is having children."

Husbands and in-laws were optimistic that a childless woman could have a child in situations when the wife (and the marriage) was still young and/or when she had proved her fertility by experiencing a miscarriage, having an ectopic pregnancy or a giving birth to a living child who later died. Moreover, the experience should not be too far in the past, not more than about three years ago. The husband and family were kinder towards the wife in the few situations (in the present study only 2 out of 69) that the problem was known to be with the husband.

Usually the reactions of the husband and in-laws were similar; in only 11 of the 69 cases of women in the infertility survey did these differ. In five cases a woman's husband continued to support his wife while her in-laws harassed her

and pushed the husband to take another wife and have (more) children. In those cases the bond between husband and wife must have been stronger than that between the man and his family. This is quite exceptional in Yoruba patrilineal society where the wife remains the outsider and the relationship between spouses is usually not very close.

A 42 year-old Pentecostal woman has been married for 18 years as the only wife. She has no children, but had three miscarriages, the last one was six years ago. She has been to two public hospitals before LIMH and had a removal of fibroid done. The providers say her infertility is due to hormonal problems: "My husband is very caring and understanding but at times he feels bad about it. Initially my family in-law posed a lot of problems. They wanted him to get another wife, but he refused and they have since left us to our problems."

A 38 year-old Muslim farmer is the third wife of her second husband whom she married in 1996: "I was married before in 1983 when I was 23. After one year of marriage I had a stillbirth. After that I did not conceive again. I feel that the baby that I gave birth to must have damaged my womb, because it was very big. Ever since the birth of that baby I have been feeling pains just before menses. My former husband really disturbed me and was very impatient. He married another woman just before I left him. My present husband understands me and does not threaten me. [He has children from his other wives.] However, my in-laws and especially my mother-in-law disturb me a lot and have already asked me to leave the house."

Even more exceptional were the six cases in which the in-laws supported the woman, while the husband did not. In three cases, the husbands already had a child from either her or another wife; therefore the family was not concerned about the continuation of the patrilineage. The three other women were recently married and the husband was impatient, but the family was not, at least not yet. In these cases, the man probably went quickly for a solution to the infertility problem, due to tensions between the husband and wife. The husband of one woman married again after two years. His second wife bore him a child, but he is still impatient with the first one who is childless. She continues to try all sorts of treatments to conceive.

A 29 year-old woman had one child who died young, shortly after she married in 1990: "My husband could not wait any longer and had to marry a second wife five years ago [two years after she married him], who now has a four-year-old child. My in-laws are still quite sympathetic towards me. I have wanted to have a child for seven years now. I went to two *olomo wewe* in the past five years. One said I had *aran giniṣa*, while the other said my womb was

not strong enough to hold a foetus. I just started last week in the general hospital, because friends had told me that the doctor there is really good."

This section indicated that the reactions of husbands and in-laws are not always as negative as common opinion would suggest. I think this is a reflection of the power relations within marriage and the outsider status of the wife. Husbands and in-laws are not as negative as would be expected from community perceptions, in part because there is usually an accepted way out of a childless life for men and a way for his patrilineage to get children. However, even a relatively positive attitude is cold comfort for women with infertility problems, for even if the husband and in-laws are presently supportive, their attitude may change at any time. Women derive their status in the patrilineage of their husbands first and foremost by producing children. Children are her assets in the family of the husband; without them she will have nobody to support her in the future. The woman herself however, cannot express her anxiety, sadness and feelings of personal inefficiency. She will be sensitive to any comments of family and community members who may refer to her as the woman without children. Gossip may easily begin, for any infertile woman is suspect, and if she behaves 'strangely', this may be considered as a sign that she is a witch.

Infertility and abortion

Some of the experiences presented earlier in this book have illustrated the dual relationship between abortion and infertility: Infertility and abortion can be one another's cause as well as effect.

Infertility as cause

The threat of potential future infertility alone is sufficient to prevent women from using modern contraceptives. The high preference for contraceptive methods other than modern ones has been described in Chapter 7 as a major contributing factor to unwanted pregnancies and consecutive induced abortions. In this way, fear of infertility indirectly causes abortion, since most unwanted pregnancies of Yoruba women are aborted. Some of the common modern drugs not indicated for contraception, but nonetheless used as such by many women, may cause infertility. Routine use of menstrual regulation drugs such as Menstrogen may cause hormonal imbalance, as might frequent use of the emergency contraceptive Postinor.

In Chapters 3 and 5, I described another way in which the threat of infertility might indirectly cause abortion. The present economic crisis in Nigeria causes premarital pregnancy to be an alternative norm in some poorer parts of Yoruba society. Girls must increasingly prove their worth as a wife, i.e. their fertility, before marriage. This constitutes a big risk for girls, because men may mislead them into getting pregnant and then deny responsibility for a resulting pregnancy. In such cases, most girls would abort the pregnancy that has now become unwanted.

Infertility as effect

The present study cannot give definite figures on infertility as an effect of abortion, but the ample number of women with abortion histories who later had problems conceiving or carrying a pregnancy to full term indicates that there is a relationship. Although all these cases are sad, the most painful are those of single girls who had an unsafe abortion and, because of complications, will never be able to conceive again. These women must now face the difficult task of coping with their childlessness because of secondary infertility. The narratives of Ronke, a 17 year-old domestic servant and Amaka, an 18 year-old secondary school student illustrate how an unfortunate decision early in their lives will negatively affect the rest of their lives. (We 'met' these two girls already in Chapter 5.)

Ronke is a 17 year-old house-girl, who went up to primary six with her education. She aborted her first pregnancy that resulted from her relationship with her stable boyfriend, who is a house-boy, because they did not have money for a baby and both were afraid to lose their jobs: "We did not have enough money to do D&C. My boyfriend bought some drugs for me and he assured me that they would abort the pregnancy quickly. I had some pains that night, but it was not much. Four days after taking the four white pills I got severe lower abdominal pain and started bleeding heavily with big clots coming out. I was very afraid and thought I was going to die. I felt helpless and knew that if something was not done immediately I would bleed to death. I wanted to go to the hospital immediately. I shouted for help and luckily my boss came. She brought me straight to a private hospital in Ikoyi [an area of Lagos]. I was then referred to LIMH after they had given me some injection to relieve the pain. I regret ever to have considered abortion. I should have given birth to the baby, even though I would have lost my job. Now I will not be able to get pregnant or have a child to call my own. I wished I were dead instead of alive." [Ronke's uterus was ruptured. In LIMH, the doctors removed her uterus and fallopian tubes. She will never be able to conceive again.]

Amaka is an 18 year-old student in JSS3. She got pregnant (her first pregnancy) from her boyfriend, who is employed and is just 19 years old. She delayed aborting for five months because they did not have money. A nurse in a private hospital did the abortion: "Two days after, I started feeling pains all over my abdomen and body. I thought the nurse did not remove the baby when she was doing it and moreover I was heavily sedated and did not know if the baby was still there. I went back to the hospital and met the same nurse who gave me some drugs but it did not stop the pain. The hospital is not far from my house so I could just walk over there. The next day I started bleeding profusely and the pain became more severe. I only told my sister that I had bleeding and pains and she asked her husband to bring me to a private hospital. She herself had just delivered a baby. I was admitted for one week. Only in the hospital did I confess what I did to my sister. Only my girlfriend and boyfriend had known about it from the beginning. When my condition deteriorated the doctor then referred me to LIMH. My sister's husband and my friend took me there. I regret very much that I did the abortion. If I had known that it would bring me all these problems, I would have given birth to the baby. I will never have sex again until I am ready to get married." [Amaka's cervix is necrotised and she will never have a normal delivery, if she is able to conceive at all.]

The various surveys conducted for the present study revealed only a few cases in which a previous abortion *definitely* was the cause of infertility, e.g. the uterus had obviously been damaged, or the cervix had become incompetent. In other cases, the histories of infertile women made us *suspect* abortion to be the cause, and sometimes women themselves believed this to be so. Nine of the 59 women with complaints of secondary infertility in the infertility survey believed that a previous abortion was the cause of their infertility problems. Okonofua (1996b:958) estimated that in Nigeria, a history of previous induced abortion was associated with a sevenfold-increase in incidence of secondary infertility. Some indication of the magnitude of infertility after abortion can be deduced by analysing the reproductive histories of the 59 women in the infertility survey with secondary infertility. Table 8.10 summarises the outcomes of their first pregnancy.

As many as 37% of the first pregnancies of the 59 infertility clients were aborted, but these figures do not indicate whether this abortion was the cause of the woman's present infertility problems. However, further analysis reveals that only 3 out of the 22 women who aborted their first pregnancy bore a live child later (two of these children died at a young age). The others had either not been pregnant since, had miscarried or had another abortion. Additionally, two women who already had one or more children before they had an abortion did not conceive again after their abortion, while one woman had only miscarriages

afterwards. Thus, data of the present study suggest that more than two-fifths (25 out of 59 cases) of secondary infertility problems might be due to induced abortion.

Table 8.10. Outcome of first pregnancy of 59 women with secondary infertility in the infertility survey

<i>outcome of first pregnancy</i>	<i>percent</i>	<i>number</i>
Live birth	42%	25
Induced abortion	37%	22
Miscarriage	17%	10
Stillbirth	2%	1
Ectopic	2%	1
<i>Total</i>	<i>100%</i>	<i>59</i>

Another source of data from the present study that indicates infertility is a result of abortion are the interviews with 41 women who came to the hospital with complications of abortion. These women usually had severe complications due to an incomplete abortion, i.e. retained products of conception, death of foetus inside the womb or damage done to the uterus and internal organs.²⁰ Table 8.11 indicates that more than half of the women (56%) who came to the hospital with complications will or might have lasting complications of their abortion, according to their patient files. The third column in Table 8.11 shows the marital status by a specific outcome and the fourth column, the number of women per outcome who did not have children yet.

Table 8.11. Outcome of abortion complications of 41 women who came to the hospital with complications, by marital status and childlessness status

<i>outcome of abortion complications</i>	<i>all</i>	<i>marital status</i>	<i>without children</i>
(Probably) lasting complications	23		13
Risk of problems with getting pregnant or miscarriage in next pregnancies	(14)	7 single, 6 married, 1 separated	(5)
Poor status - not know yet outcome	(5)	4 single, 1 married	(4)
Death	(3)	3 single	(3)
Not able to get pregnant again	(1)	1 single	(1)
(Probably) no lasting complications	18	3 married, 14 single, 1 divorced	13
<i>Total</i>	<i>41</i>	<i>10 married, 29 single, 1 separated, 1 divorced</i>	<i>26</i>

Of the 23 women with (likely) lasting complications, 13 had no children yet. All of these 13 women were single. Three of these 23 women died tragically. For the ten surviving women, childlessness will be a serious problem for the rest of their lives. Ronke, in the history at the beginning of this section said she would rather be dead than childless. Toyin, the girl in the prologue died because her parents decided against a lifesaving surgery after they considered the future misery that a childless life would mean.

Conclusion

Although the threat of infertility and the expected stigma attached to it are both exaggerations of the actual incidence of sterility, childlessness and experienced stigma, infertility is indisputably a central issue in Yoruba society. It poses enormous problems for the persons affected, especially for women. The threat of infertility for a woman is real: She fears being stigmatised, when infertility is believed to be her own fault, and ostracised, when she is replaced by another wife. In contrast with married men, married women with infertility problems have very few strategies available to them to secure children.

Infertility is usually an affair of the patrilineal family and not a private affair between husband and wife. It is painfully striking throughout this chapter that in Yoruba society women bear the bulk of the negative repercussions of infertility, whether or not *they* are infertile. Blaming women for infertility is common in many other African societies (see also Sunby & Jacobus 2001:259-260). Women are always the prime suspects when a couple cannot produce children; they are the indicators of fertility because *they* get pregnant and not the husbands (although it is acknowledged that men can also be infertile). In the best scenario (for the infertile woman), her infertility is believed to be the result of medical problems. In the worst case, she is accused of having caused the problems through her deviant behaviour, i.e. by transgressing taboos, offending others, promiscuity, use of modern contraception or abortion. Studies in sub-Saharan Africa on clinical causes of infertility, that could indicate the gender distribution of infertility, are scarce. The only Nigerian study that I know of contradicted the popular belief that women are the main culprits: of 114 infertile couples, men and women were about evenly responsible for infertility (Chukudebulu et al. 1979 cited by Mayaud 2001:74).²¹

As Yoruba society condones problem-solving coping strategies for men more than it does for women, women's problem-solving strategies usually take place more in secret; surreptitious behaviour always increases stress. Voluntary emotion-focused coping strategies with infertility are near to non-existent.

Consequently, in Yoruba society, there are no social models that show that a couple, woman or man, *could* successfully live with infertility, as is the case in Northwest Europe and North America.

The threat of infertility prompts women more than men to engage in practices that are risky and detrimental to their health. For example, many women do not use modern contraceptives that they fear will damage their fertility when they want to prevent pregnancy, and so end up with an unwanted pregnancy. Some drugs not indicated for contraception, but that are nevertheless used as such, may even cause infertility. To prevent or treat infertility, women may decide to 'wash' the uterus by having a D&C after either miscarriage or delivery, or whenever they believe they have an unclean uterus. Private practitioners willingly perform the procedure for financial gain, even if there is no medical indication. Inhorn (1994b:308) found the same phenomenon in Egypt, although there it was usually the biomedical practitioner who prescribed it, whereas among Yoruba the women themselves decided to have it done. Inhorn stated that D&C has absolutely no therapeutic role in treatment of infertility. I would add that an incorrectly performed D&C might even result in the opposite: It may bring about infertility because of damage done to the uterus.

Given the reality that infertility after abortion is common, and that most persons say they are against abortion because of the health complications, including infertility, it is surprising that so many women have an abortion. Why would women risk the ultimate affliction of infertility by having an abortion when infertility is the very thing they try to evade by not using modern effective contraception? In the concluding chapter I will try to explain these paradoxical practices.