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Secret strategies: Women and abortion in Yoruba society, Nigeria

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EXPOSURE OF SECRET STRATEGIES

In light of previous researchers' reservations about the possibility of obtaining reliable information on the sensitive topic of abortion, it is remarkable that the present study encountered very few problems with this task. Even in a survey setting, discussing abortion and getting women to share their personal abortion experiences was not extremely difficult. This seems to be evidence in support of the study methodology, which implied methodological triangulation and gradual development of the data collection tools. We used broad definitions of contraception, abortion and infertility and asked about abortion in the context of other fertility regulation practices, paraphrasing any possibly ambiguous terminology.

The reality versus the rules

Abortion is no doubt a considerable public health problem in Nigeria. According to earlier cited researchers, an estimated 10,000 women die from abortion annually, and abortion deaths constitute roughly one-third of registered maternal mortality (Okonofua et al. 1992:75; Renne 1996:485). These hospital-based figures may be gross underestimates: The histories about women who have died from abortion that we collected indicated that one-quarter of these women died at home and another 6% on the way to the hospital. These women will never appear in abortion statistics, because another cause of death will be officially reported instead. Respondents in this study acknowledged that abortion deaths are nowadays common: 28% of women interviewed in the community survey had personally known a girl or woman who had died from abortion.

In contrast to abortion-related deaths, most abortions without complications are not 'visible' because women usually do not talk about them. Figures from different surveys we conducted confirmed the high abortion prevalence: 47% of women in Lagos town and 17% of women in Epe, a rural area, reported having had one or more abortions. These are higher figures than appear in most cited studies (see Chapter 1). Seven percent of women in the community survey

(urban and rural areas combined) had an abortion in the year preceding the survey, which surpasses the annual abortion rate of 4.6 calculated by Henshaw et al. (1998:161).

Both married and single women have abortions, but single women appear to run considerably higher risk than married women do. Single women had more abortions, more unsafe abortions (past the first trimester abortion and/or with unsafe methods and providers) and more often delayed getting adequate treatment if complications arose. Of the 1073 recorded abortion experiences, 77% were of single women. Forty percent (40%) of abortions of single women were unsafe compared to 30% of those of married women. Secondary schoolgirls appeared to be the most vulnerable group of all: 20% of the 1073 abortions were of secondary schoolgirls, 51% of their abortions were unsafe and in the histories about women who had died from abortion, 47% were secondary schoolgirls.

The high abortion prevalence is in blatant contradiction with the societal rules and norms that oppose women aborting an unwanted pregnancy on most grounds. Young and old, males and females categorically disapproved of abortion; a pregnancy resulting from rape was the only exception. The main reported reason for condemning abortion was that it carries serious health risks, such as infertility and death. Of course, the focus on health risks is a sincere concern for the well-being of an individual woman, but in the wider context of Yoruba patrilineal society, a woman who dies is also considered a lost 'investment'. If the woman who dies was single, her death means a loss for her parents who have raised her and may have sent her to school or had her learn a profession in apprenticeship. Daughters, and the educated ones more so, are investments to their parents. An educated daughter will fetch a higher bridewealth and will usually also have a higher income, part of which she will continue to contribute to her own family after marriage. A good marriage partner is advantageous to the parents of the girl because the patrilineage she marries into is to support the wife's family, even after the husband's relatives have paid a bridewealth. Their support is not only financial; they will facilitate access to connections that will help, for example, with finding employment, promoting business, or getting a study place in university. If a married woman dies of an abortion, she is a lost investment for her husband and in-laws who paid the bridewealth, as well as for her own relatives.

Secondly, abortion is considered immoral because abortion is killing a human being and offending the work of God. Single girls who abort are considered doubly immoral, because they have clearly broken the societal rule that prohibits them from having premarital sexual relationships. The focus on the 'immorality' of abortion can also be seen as a lost investment, because girls who abort are obviously not flawless and will be 'cheaper' wives (see also Varkevisser

1995:189). The immorality of married women who abort carries further moral implications: They have withheld a new member from their husband's patri-lineage, and their fidelity will be doubted. This is especially so if a woman is found to have aborted without the husband knowing. She will be under suspicion of having been pregnant by another man.

Abortion decisions in the socio-economic context

The societal rules are not the only factors that influence individuals' behaviour, so the finding that the reality of abortion is different from societal rules related to it is not startling. Sociocultural, economic and political factors influence the reality of abortion as well as the rules. Situating abortion in women's societal context makes clear *why* women violate the rules against abortion and why single women, and in particular secondary schoolgirls and apprentices more often than married women, resort to the abortion of unwanted pregnancies. The same context influences the choice of abortion methods (with more single women resorting to unsafe abortion), as well as the way of coping with possible complications after abortion.

Generally, single women have more to lose from an unwanted pregnancy than married women do. A pregnancy highlights their deviance from dominant rules that forbid premarital sex. Additionally, since education is believed to be the avenue that leads to success in life, girls do not want a pregnancy to spoil these chances. Because school authorities expel pregnant girls from school, they want to avoid pregnancy. If they get pregnant, girls are generally reluctant to expose their pregnancy and ask their parents for advice, because traditionally, sexuality is not discussed between parents and children. All girls and single young women fear the reaction of their parents to their pregnancy: They will scorn them, stop supporting them financially (e.g. not pay their school fees), or otherwise prevent them from aborting. Alternatively, parents may force them to marry if the boyfriend and his family accept the responsibility for the pregnancy. If the boy and his family reject the responsibility, having a baby will give a girl less chance to find a good marriage partner. Having a baby may thwart all single women's dreams and plans for the future. Generally, premarital pregnancy is a source of great shame that can stain a woman's reputation throughout her life.

A secret abortion is, from the viewpoint of single women, the best way of coping with the stressful situation of unwanted pregnancy; 76% of the 427 single women in this study who had an unwanted pregnancy decided to abort it. Most single women decided for themselves to abort, but asked for social sup-

port from female friends and male partners for the execution of their decision. They especially involved female friends in the choice of abortion methods and as companions when they went to the abortionist. Partners usually concurred with the choice for abortion, *they* too did not want a pregnancy to get in the way of their plans and be forced to marry their girlfriend at this stage. Partners normally did not advise their girlfriends on the practicalities, but did often help in paying for the abortion. The need for secrecy 'pushed' many girls and young women to rely on unsafe abortion methods such as self-abortion with dubious medicines from chemist shops or to resort to procedures at obscure hospitals. The same wish for secrecy caused many of the single women with abortion complications to hide them. This entailed even more risks for their life than the abortion itself, as their confidantes were not around to help them.

The finding that schoolgirls are a high-risk group for abortion nurtures the ambiguity surrounding the influence of education on the health of women. Generally, it is accepted that the relationship is positive, because educated women are likely to marry at a later age, have smaller families, use family planning methods and take better care of their own and their children's health (see also Varkevisser 1995:187). However, as this research indicates, education may also be an indirect cause of morbidity and mortality. Longer education leads to later marriage, increased risk of premarital pregnancy, higher motivation to abort pregnancies, with more often unsafe methods, all of which are detrimental to a woman's health.

The societal context of married women naturally differs from that of single women. According to prevailing norms, all children conceived in marriage should be welcome both by the wife and her husband. However, the ambiguous relationship with her husband and in-laws may cause a wife to have views about the desirability of a pregnancy different from those of her husband and in-laws. On the one hand, the husband and in-laws who have paid bridewealth for the woman 'own' the wife's sexuality and reproduction according to dominant rules. A wife is not supposed to make fertility regulation decisions on her own, but instead should comply with the wishes of her husband and in-laws. A wife would like to comply, because she depends on her husband and in-laws for her position in society. On the other hand, most Yoruba women have a certain financial independence from their husband and in-laws. As women are, for a large part, financially responsible for the upbringing of their children, they will feel the burden of an additional child more severely than their husbands do. In light of the increasing economic problems that most Nigerian families are experiencing, married women often had financial reasons underlying their motivations to abort. They wanted to postpone or stop childbearing because they could not afford another child, either at this moment or at all. In the best-case

scenario, their husbands concurred and supported their decision to abort, often secretly from their in-laws; in the worst-case scenario, women aborted secretly, unbeknownst to even their husbands. About half of the husbands of married women who aborted in this study did not know about their wife's abortion. More women whose husbands knew about the unwanted pregnancy had safe abortions than those whose husbands did not know about it. The position of women who become pregnant from an extramarital affair can be compared with that of single women. Both groups did their best to preserve the secrecy of the abortion to hide their forbidden sexual relationship.¹

The biggest 'advantage' that married women have over single women when confronted with complications of induced abortion, even if they abort secretly from their husband, is that they can always pretend that they have had a (spontaneous) miscarriage. Nobody is surprised if a woman has a miscarriage even if they were not aware of the pregnancy, because Yoruba women normally do not announce they are pregnant, but wait till the pregnancy starts to show before proclaiming it, often even to their husband. At least initially, the miscarriage will solicit everybody's empathy and support to go for treatment of the problem. Married women in this study usually went for treatment of abortion complications more promptly than single women did.

In addition to reasons of secrecy, having less access to financial and information resources causes girls and single women to resort to unsafe abortion more often than married women. Girls and young women do not know where to go for an abortion and where to get funds to pay for it. Their limited financial resources make them resort to unsafe abortion providers because these are usually cheaper than safe ones. Most married women, even if their husbands are not involved, have a wider network of friends and neighbours (family is hardly involved in abortion matters) who could help them with information and funds if needed. At the very least, they can always ask for help from the doctor, midwife or TBA where they delivered their babies.

Abortion services' context

In addition to their desire for secrecy and the limited finances with which to pay for the abortion, the illegal status of abortion in Nigeria fosters unsafe abortions and inadequate treatment of its complications. Under the Nigerian law, both the aborting woman and the provider performing the procedure can be jailed. Abortion is thus a secret covenant between the provider and the woman. When complications occur, the woman or her family cannot hold the provider responsible, because the woman on whom the abortion was performed likewise

committed an offence, something that neither the woman (if she is still alive) nor her family would like to disclose. Safe and unsafe providers are equally punishable when providing abortion services, which indirectly protects malevolent providers. Thus, the government does not curb the dangerous abortion practices of non-licensed private clinics, back-street abortionists, chemists and traditional healers. These unsafe providers are widely available, because many individuals, who need to make a living in times of economic austerity, abuse the high demand for abortion and offer unsafe abortion services. Some of the (unsafe) providers in this study admitted, 'We also have to eat'. The government does not even carry out quality controls on abortion procedures in registered private hospitals where safe abortions *could* be provided. In the case of complications occurring at the provider's place, abortionists will be hesitant to refer women to specialist hospitals out of fear of exposure. They will try instead to treat the woman themselves, often with disastrous consequences, as some of the histories in this book have illustrated.

The disparaging attitudes of providers contribute to the fact that the thresholds of quality private hospitals are much higher for single than for married women, *given* that both have money to pay for the services. Providers usually have a less disapproving attitude towards married women than towards single women who want an abortion. Pregnant girls and single women are always condemned because they had a socially reprehensible premarital affair. Sub-standard abortionists in private hospitals and back-street abortionists as a rule do not have or at least don't *show* this condemning attitude, because they are in this 'business' for money. They realise that with such an attitude they would cut off their own clientele.

Coping with an emergency

Even if it is understandable that their wish for secrecy, their financial constraints and the sub-standard available abortion services are major factors influencing women to resort to unsafe abortions, one could still wonder why women willingly risk their health. Most girls and women (and boys and men) *know* which abortion methods are relatively safe and which are unsafe. They know that unsafe methods and late abortions pose a higher health risk, the worst risks of all being infertility and death. Public opinion is mostly against abortion because of the health risks involved. The reason why many women, and especially young girls and secondary schoolgirls, still resort to unsafe abortion methods may be firstly that they underestimate just how high the risks are. They do not have accurate information on the possible complications of specific methods.

The crisis nature of many unwanted pregnancies leads girls and women to make on-the-spot coping decisions without carefully exploring and weighing the alternatives, i.e. the advantages of having a more risky but secret and cheap abortion over those of a safe but more expensive and less secret abortion.

Secondly, avoidance coping seems to play a role in the choice of unsafe abortion methods, where girls and women ignore the stories about possible negative side-effects and ineffectiveness. Just like everyone, they tend to believe what they *want* to believe; that which suits them is the most credible. They have a problem at hand that they urgently need to solve. If rumours are spread that a certain drug should not be used during pregnancy, girls and women want to believe it can *abort* their unwanted pregnancy. Moreover, as histories in this book have illustrated, if they hear about some women having aborted successfully with these methods, they have proof that they work, even if other stories stress the ineffectiveness or the health risks involved.² The same applies to hearsay about a woman who has successfully aborted in a certain chemist shop or with a back-street abortionist. The fact is, that even with relatively unsafe methods and providers of abortion, many women succeed in aborting secretly without serious complications: Of the women who survived an unsafe abortion in this study, 'only' about one-quarter reported complications. Women will avoid thinking about the simultaneous warnings against unsafe methods and abortionists if they are desperately in need of a secret or cheap abortion. This is especially true of girls and single women, and among them in particular schoolgirls, who are usually more desperate. In theories of coping, women who aborted successfully with less effective and unsafe methods act as 'social models'. These social models increase other women's self-efficacy belief in being able to solve the problem. They cannot hear the voices of those women who did not survive, and choose to ignore the stories about them.

Abortion and contraception

Most abortions could have been prevented by the use of effective contraception. The impression prior to the present study, based on previous research, was that Yoruba women severely under-use contraception; 1990 DHS figures indicate that only 15% of married Yoruba women were using contraceptives (Bellamy 2000:110). Given the fact that modern contraceptives are widely available in Nigeria, this led some researchers to conclude that women *prefer* abortion to contraception as a method of birth control (see also Otoide et al 2001:80; Renne 1993:349). This assumption is in agreement with the common perception that persons are usually more inclined to act on a problem than to

prevent the problem. This study proved the aforementioned assumptions wrong in two ways. Firstly, the recited experiences indicate that for the majority of women, abortion was a way of coping with an immediate problem rather than a contemplated and preferred way of birth control.³ Researchers sometimes forget that having an abortion is not a pleasant experience that women would *like* to have or to repeat. Many interviewed women, especially those married, reported they started using (effective) contraceptives after their abortion, to prevent repetition. Secondly, in contrast to studies that found low contraceptive use, the present study revealed that about 75% of married and 67% of single women who did not want to become pregnant *tried* to prevent it – indicating that in general women prefer prevention to abortion. The problem was that more than half of the users did not use modern effective contraceptives. Instead, they used a variety of other methods and measures including traditional, natural substances and modern drugs not indicated for contraception (such as antibiotics, purgatives and menstrual regulation drugs), and home methods (such as drinking salty water or douching with lime-juice).

Several service and sociocultural factors, which are somewhat different for married and single women, are responsible for women using non-modern contraceptives. Though modern contraceptives are widely available in public clinics and are also affordable to most Nigerians because they are subsidised, public family planning services are geared towards married women and inaccessible to girls and most single women. A prohibitive factor to the use of the public services for many women, both single and married, is that these services are not private and confidential. Many women want to keep their use of contraceptives a secret, because dominant norms oppose contraceptive use both by married and single women. In public clinics, women have to register their names and may fear that staff will inform their family. Methods other than the modern contraceptives can be purchased and used more privately. Single girls and young women especially do not want others to think they are immoral because of their routine use of contraceptives or because they carry condoms; they would rather use post-coital methods that are not indicated as contraceptive or apply periodic abstinence. This also helps them maintain their moral self-image; most girls would not like to identify with the 'bad' girls.

Another factor that works against the use of modern contraceptives and in particular oral contraceptive pills, IUCD and injectables, is that they have highly ambiguous connotations, which make women hesitant to use them. Information and counselling on them is deficient (most users get them from chemist shops and drugs peddlers where little information is given), which results in incomplete knowledge. Contradictory stories circulate about their adverse side-effects, ineffectiveness and impairment of future fertility. The

threat of impairment of future fertility was often the most decisive motivation for not using modern contraceptives for girls and single women, as well as for married women who had not completed their family. In the context of the paramount importance of fertility in Yoruba society, this fear of infertility is understandable.

Abortion and infertility

Yoruba consider a life without children useless, both for women and men. In polygynous Yoruba society, the threat of infertility is higher for women than for men, because within marriage, women with infertility problems have less coping strategies to secure children than men do, who can always marry an additional wife or have 'outside' children which they can acknowledge as their own. Moreover, women are the 'indicator' of a couple's infertility and will be blamed. Yoruba have many explanations for infertility, both natural and spiritual. Infertility may be the penalty for the violation of dominant rules and norms, often through punishment by family ancestors or deities who are the guardians of Yoruba society. Yoruba are highly religious and strongly believe in spiritual forces. The threat of infertility as a penalty therefore helps to perpetuate the dominant rules, and restrains especially women from dissident behaviour. An infertile woman may be stigmatised by society, replaced as a wife and will likely suffer from feelings of personal inadequacy.

At the same time, the fear of infertility has also caused some societal norms to change. This study described how nowadays, under pressure of economic austerity, some families want proof of the usefulness of a girl as a wife, demonstrated by her conceiving or even having a baby before marriage. This is in direct opposition to the traditional norm that places a high value on a bride's virginity. This new norm is a demand that makes future brides highly insecure. On the one hand, without any marriage formalities, boyfriends may easily end the relationship if a girl becomes pregnant. On the other hand, girls may gamble and demonstrate their fertility by pregnancy in an attempt to lure a desirable man into marriage.

Infertility may be the indirect cause of abortion in at least two ways. The fear of it makes women not want to use effective contraceptives when they want to prevent unwanted pregnancy. Alternatively, when future wives have to or want to prove their fertility, they get pregnant, but are then abandoned by their husband-to-be. Infertility may also be the direct effect of abortion, when, as is often the case in Nigeria, the abortions are performed by unqualified, or inexperienced providers, or under unsafe conditions and result in secondary infer-

tility. Many of the interviewed women with abortion complications cannot conceive anymore, or if they can, the pregnancy will only end in miscarriage.

The explanations for women's seemingly irrational behaviour, i.e. not using effective contraception because of fear of infertility, and then resorting to abortion, which carries a high risk of infertility, have to be sought in the emergency nature of the problem of unwanted pregnancy. With contraception, women can usually make planned decisions: They weigh advantages and disadvantages of certain methods. For many Yoruba women, the disadvantages of modern contraceptives – one of them the possible impairment of future fertility – outweigh the advantages. With unwanted pregnancies, women usually do not have time for informed decisions, but have to decide on the spot: The advantages and disadvantages of abortion are quickly weighed. For many women, the immediate advantages of solving an unwanted pregnancy outweigh the disadvantages of risks of future health problems, including infertility, that abortion may bring. Abortion proved to be the most common way of coping with an unwanted pregnancy; nearly four-fifths of single and married women with an unwanted pregnancy opted to abort it.⁴

Conclusion: Female agency and secret strategies

Narrated experiences indicated that Yoruba girls and women actively sought to maintain their social position (as flawless daughter or beloved wife), aimed to prevent (more) financial problems and tried to safeguard their future (education and career opportunities) by aborting an unwanted pregnancy. Many girls and women also actively intended to prevent unwanted pregnancy by using different types of contraceptive methods or by abstaining. These women opposed prevailing traditional norms that frown on contraceptive use for both married and single women, which reason that single women do not need contraception and that husbands make decisions about contraception for their wives (and often do not allow her to use it). Women's interests may clash with societal rules, when they want to decide for themselves when to have children, or to prevent an affair that is purposely casual from becoming more serious by being forced to marry the father of an eventual pregnancy. They may also want to hide secret sexual affairs, which a pregnancy would inevitably make public.

The use of contraception and abortion are signs of 'obvious' female agency (even if they are covert), although also for some women keeping an unwanted pregnancy or not using contraception is an active choice and not 'just' passively following the majority rules that forbid these practices. Having an abortion and using contraception could be considered as 'strategies' of individual women,

because most of these women are conscious of what they are doing and why they are doing it. On the other hand, one could argue that this female agency is merely 'tactics', because it is severely conditioned and constrained by many cultural, social and material factors as was implicit in the histories presented and in the analysis thus far. The dependent sociocultural and economic position of girls and women has caused knowledge about safe and effective methods to be inaccurate, and services to be inaccessible, unaffordable, inconvenient and/or unsuitable (for instance because they are not private). The result is that some women do not accomplish the aim of their strategies, because the methods they used failed and resulted in negative health and social repercussions.

One of the main constraints to women's agency is the gender inequality in Yoruba patrilineal society in the domain of sexuality and reproduction. Without making any conclusions about the all-pervasiveness of women's subordinate position in all domains of Yoruba society, it can be said that women vis-à-vis men are undoubtedly in a disadvantaged position in the expression of their sexuality. If women, whether single or married, express their sexuality outside the rules and norms of their society, they have to do so secretly, otherwise they will be stigmatised. For girls, experimenting with their sexuality is not socially accepted, and often leads to far-reaching negative consequences including the cessation of their education, being stigmatised as immoral or being forced into marriage. The only way out is abortion and the risk of suffering and resulting complications. For boys, sexual experimentation is much more acceptable and does not have such negative results. Boys and men often have a double moral standard: They try to lure girls and single women into a relationship and have unprotected sex with them, while at the same time they adhere to the rule of condemning premarital sex for girls. Husbands have the right to control their wives' sexuality and reproduction, and they exercise that right. Societal rules do not allow women to have extramarital affairs, which would interfere with their husbands' rights, while they condone such affairs by men who may also marry more than one wife. Husbands have the right to decide about their wives' use of contraception. The distrust of his wife's fidelity (sound or not) may cause a husband to forbid her to use modern contraceptives. She may end up with an unwanted pregnancy that she copes with, often secretly, by abortion. The histories in this book illustrate how women may use ineffective contraceptives because they are more suitable in their situation, are 'pushed' into secret abortions that are usually unsafe and then hide abortion complications. This gender discrimination in the field of sexuality and reproduction negatively influences the health of girls and women (see also Varkevisser 1995:186).

The relationship between generations is another important factor that conditions and constrains women's agency in Yoruba society, especially that of girls

and young single women. Children are socialised not to question the opinions of adults. There is very little communication about sexuality between parents and children. Adults do not inform youth about sex and prevention of pregnancy, because they believe this knowledge would entice youth into trying to experience it. Girls who are sexually active usually have only inaccurate information from peers and magazines about how to prevent pregnancy, and often get into trouble by using ineffective contraceptives or none at all. When girls find themselves with an unwanted pregnancy, they are reluctant to inform their parents out of shame, and usually make decisions on their own, with or without their normal confidants, girlfriends and partners.

How should one evaluate this female agency of abortion? Seen 'positively', from the viewpoint of individual women, these women tried to influence their 'fate' and pursued their own interests. They took the initiative to manage their reproductive lives. Some scholars like Indriso & Mundigo (1999:50) and Greenhalgh (1995:25) argue that these are female strategies that may challenge the patriarchal system and may even alter the system in the end. However, the unintended negative effect of their agency, as we have seen in this book, may be that it leads to severe health problems and social repercussions.

For various reasons I doubt whether the strategy of individual women, and I refer to abortion now, will change the patriarchal system in respect to women's say over their sexuality and fertility regulation. First, we should not overlook the fact that Yoruba girls and women do not intend to resist the rules and norms of society. Their lived experience is not one of resistance. By aborting, they publicly try to adhere to these rules and they excuse themselves for their deviant actions that were reportedly instigated by the situation they found themselves in. Most women, even those who have had an abortion, disapprove of it and morally evaluate other women who did it, referring to the norms they themselves violated.⁵ Generally, individual Yoruba women do not publicly rebel against their disadvantaged gender position in the domain of sexuality and reproduction. Many Yoruba women consider their disadvantaged position and the behaviour required of them, dictated by traditional norms of patrilineal society, as inevitable.⁶ Instead, as is part of their upbringing, they emotionally cope with this situation by adjusting. In fact, my Yoruba female friends advised me to do the same. Individual women may try to actively find room to manoeuvre within the system to their advantage. Yoruba women, as all Yoruba, are very resourceful, pragmatic and ambitious and they have tactics and strategies of manipulating men (and other women) and maximise their personal interests within the constraints of societal rules. If they violate dominant rules and norms, they would usually do so secretly because if they would do so openly,

they risk being stigmatised. Since they *consciously* act secretly, secrecy may be considered a strategy (more than it would be a tactic).⁷

A second reason why I believe the strategy of abortion will not change the patriarchal system is that it is not a female group strategy. As theorised in Chapter 1, alternative strategies could only change dominant rules if they are group strategies that reflect alternative norms. Yoruba women do not seem to rebel as a group against their gender position in the domain of sexuality and reproduction, in which their actions are structurally constrained by their gender role. They do not seem to have alternative group norms for sexuality and reproduction, but instead adhere to the societal norms. In a way, this is surprising, because in other domains of Yoruba society, groups of women are extremely outspoken and assertive. Yoruba market women, for example, constitute a powerful lobby group for economic concerns of women. It may be that the nature of Yoruba society inhibits the formation of female group resistance against dominant rules on sexuality and reproduction, because competition between women seems inherent in this domain of Yoruba society. Wives compete with female in-laws and co-wives for the attention and financial assistance of husbands, and single women compete for potential husbands or lovers. As explained in Chapter 3, competition, jealousy and distrust between individuals are features of contemporary Yoruba society for both men and women, although traditional norms placed a high value on co-operation and community spirit.

Secondary schoolgirls constitute a more coherent group with their alternative, although hidden, norms and practices, than women in general. Schoolgirls have more of a common goal and more of a common 'opponent'. They all strive to get their certificates and aim for a better future (in which they hope to earn a lot of money). Their first concern is their education, and they are thus not yet so occupied with competing for future spouses, as are girls not in school and older single women. Their 'opponents' are parents, school authorities and most other adults from whom they have to hide many of their questions and actions. The peer-group is extremely important for schoolgirls, as a source of information, as a role model and as protection against other groups. There are two stereotypical peer-groups for schoolgirls, the 'bad' and the 'good' girls. The 'bad' girls are those who do not conform to the dominant rules and values in society related to sexuality, and the 'good' girls are those who do follow those rules both in their beliefs and actions. Most girls would not want to be identified with the bad girls – yet they may find themselves in circumstances that would cause them to be labelled as 'bad'. Within peer-groups, alternative norms and practices might develop as a response to some common problems. Abortion might have become an alternative norm in some groups to solve the problem of unwanted pregnancy, so might preventing pregnancy with dangerous and ineffective drugs.

The service and societal context that make schoolgirls have inadequate information, which is compounded by their poor access to finances, often make girls resort to inadequate solutions.

As indicated in Chapter 1, the difference between tactics and strategy is one of gradation. It could be argued that abortion would belong more to the 'tactics' end of the spectrum, because it is usually secret and highly constrained by contextual factors. However, in view of the pragmatism and resourcefulness of Yoruba women (as all Yoruba), and their actions being conscious and purposeful, I am inclined to label abortion as a strategy, aimed at safeguarding their present and future social and economic status. Since abortion is mostly a *secret* and *emergency* strategy (and secrecy is a strategy of itself) of individual women, it is not a female (group) strategy that resists and may even change dominant rules of the patrilineal society.

Recommendations

Given the illegal status of abortion, the prevailing rules and norms in Yoruba society, the unequal gender relations related to sexuality and reproduction, the focus on fertility, the poor economy and the contraceptive and abortion services' context, the problems related to abortion seem almost impossible to solve. Still, with all these constraining conditions in mind, I believe some interventions could reduce the problems. The following recommendations are in large part inspired by participants' suggestions that were made during the participatory sessions of the present study, in which I presented the preliminary study findings. Participants included Yoruba women, men, girls and boys from the communities in which the surveys took place; secondary schoolgirls and schoolboys; and ethnomedical and biomedical staff.

Targeting young women and in particular secondary schoolgirls

Priority interventions should be directed at girls and young single women, and in particular secondary schoolgirls and apprentices (and their male counterparts). There is an urgent need for sex and reproductive health education in schools because youth lack knowledge about almost all aspects of sexuality. Students, beginning as early as the final years of primary school, need comprehensive sexuality education as a basis for boys and girls to develop responsible sexual behaviour. Education should also address unequal gender relations. Organising role-playing activities with youth in schools, youth centres or churches can be a useful way to make assumptions about gender roles explicit, and let the role

players analyse negative effects of certain gender relations. The sexuality education should teach youth how to prevent pregnancy, warn them against the ineffectiveness and side-effects of some methods used as contraception and make them realise the dangers of unsafe abortion methods. Since the peer-group is an important point of reference for youth, peer education is an effective way to spread messages. These should not be only messages by the 'good' girls and boys, who promote premarital abstinence; the so-called 'bad' girls and boys should serve as peer educators and educate youths on safe sexual practices as well.

All able adults, including parents, teachers, community and religious leaders should be involved in educating youth on sexuality. This 'openness' may give youths confidence that they could also approach the educators when they are in trouble caused by having had unprotected sex or have an unwanted pregnancy. Empathic staff in public clinics should counsel young people and provide girls and boys with contraceptives without moralistic messages. This would lower the threshold for youth to enter public clinics. Government-established youth-friendly clinics, as presently operated by some Nigerian non-governmental organisations, would appeal even more to youth and are strongly advisable.

As a facilitating condition, it should be a federal guideline that schoolgirls who get pregnant are to stay in school and not be expelled by school authorities as presently happens. Moreover, school authorities should emotionally and practically support them, for example by allowing time for students to attend ANC. This would contribute to reducing the stress on pregnant schoolgirls that pushes them to abort the pregnancy or make them quit school quietly and shamefully before their pregnancy gets noticed.

Promoting modern contraception

Increased use of modern contraceptives, which when appropriately used are more effective than other methods, would definitely help in reducing the abortion rate. It is opportune that most Yoruba women are already trying to prevent unwanted pregnancies, although with other methods. The challenge is to motivate these women to use modern contraception (or if their religion forbids it, to receive counselling and education on how to properly use natural methods). Contraceptive service providers should tailor their information, education, counselling and provision of devices to specific target groups. They should address the ambiguity and suspicion surrounding modern contraceptives.⁸ They should also personalise their service by adequately responding to the criteria that an individual woman bases her evaluation of the acceptability of contraceptive on, which vary according to the specific time in a woman's personal history and context.⁹ Contraceptive service providers could contact

married women in MCH and FP clinics. For youth and unmarried women without children, providers should create a favourable service environment, either in regular FP clinics or in special youth clinics.

Information on Postinor and other emergency contraceptives (EC) should be given especially to girls and young single women, who often have infrequent and unplanned sex, and who prefer to use post-coital contraceptives. A serious warning should accompany the promotion of Postinor and EC promotion that reminds users that EC does not prevent STIs including HIV.¹⁰ A special warning, possibly through a public health campaign, should go out against the adverse side-effects of modern drugs such as antibiotics, menstrual regulation drugs and purgatives not indicated as contraceptive that are nonetheless widely used as such.

Providing safe abortion and post-abortion services

I strongly support the legalisation of abortion, because legalisation could contribute to making more abortions safe. If abortions were legal, the Government would be able to provide safe and cheap legal abortion services, control the quality of private abortionists and prosecute unsafe providers. However, legalising abortion is a long process, and interventions could be implemented to make abortion and post-abortion services safer, while abortion is (still) illegal. Decreased use of relatively unsafe abortion methods, increased 'professionalism' of private abortion services and improved access to high quality post-abortion care services may help decrease abortion morbidity and mortality (see also Molina et al. 1999:58).

The government, possibly with the involvement of NGOs, should initiate a non-moralistic informative health education campaign to warn against unsafe abortion methods and providers. This should be directed at everyone, females and males, but target especially schoolgirls and young women who more frequently resort to unsafe methods. Campaigns can be directed through public and private health services and mass media (radio or television 'soaps' are appealing) and involve traditional healers, teachers and religious leaders. Special warnings should go out about the use of dangerous drugs and substances for self-abortion (such as potash). At the same time, the campaign should inform its audience about the safer abortion alternatives: abortions in quality private hospitals and in an early stage of pregnancy.

Public health staff could contribute to safer abortions. Although they cannot legally perform abortions except to save the life of the pregnant woman, they can do more for women who approach them for an abortion than just sending them away. Instead, they should give these women more information

to enable them to make an informed choice. They can counsel the women on keeping the pregnancy, inform them of the safest place to get an abortion and warn the women against the use of dangerous methods and providers.

The Federal and State governments should allow the import of safe medical methods (abortion by medicine) indicated for abortion, such as RU-486 the 'abortion pill' in Nigeria, but only when the government or NGOs are willing to train providers about its use and treatment of complications. Most women would prefer a non-invasive abortion method to a D&C or MVA; moreover, medical methods are cheaper and more private (see also Indriso & Mundigo 1999:44; Le Grand 1992).

I recommend that Federal and State governments, with the assistance of donor organisations, train eligible health staff (public and private) to treat abortion complications and provide the institutions with the proper equipment for doing so, while they train and instruct other health personnel to promptly refer abortion complications to the proper institutions. The training should address staff's attitudes towards women with abortion complications; they should be taught to be empathic and keep information confidential. The medical ethics of providers' concern for their clients should conquer their possible moral and ethical objections.¹¹ The training programmes should pay special attention to counselling on modern, effective, post-abortion contraception to prevent repeat abortions. This is likely to be successful, because after abortion, women are highly motivated to use contraception. This recommended 'improved post-abortion care' training could learn from the several post-abortion care projects that have been started in Nigeria in which international organisations, in co-operation with Nigerian NGOs, train public and private health providers, both medical doctors and midwives.¹²

Focus on infertility treatment

Infertility treatment must receive the priority attention of public and private health services that it deserves in light of the primary role fertility plays in Yoruba society (as in other societies) and the adverse health and social consequences that the threat of infertility may produce, in particular for women. Contraceptive promotion may make use of this focus on infertility, by advocating the use of modern contraceptive methods to prevent STDs (only condoms) and abortion, which are major causes of infertility in Africa. On the other hand, improved STD treatment services would prevent many infertility problems, as would safe abortion services. Besides adequate prevention and treatment of infertility, lobby groups, for example in churches and mosques, should try to renegotiate the meaning and negative connotations of infertility (see also Pearce 1999:77).

Collaboration between ethnomedical and biomedical service providers

Collaboration between ethnomedical and biomedical service providers could improve the outreach, acceptability and quality of fertility regulation services. Involving TBAs in prevention of abortion problems is a powerful strategy to address such problems (see also Indriso & Mundigo 1999:44). TBAs are good counsellors and mediators, are frequently used both in urban and rural areas and have gained the trust of the old and the young. TBAs could, for example, promote the use of effective contraceptives, provide condoms, educate and counsel women, men and youth on safe fertility regulation practices and refer patients to appropriate services for contraceptives other than condoms, for safe abortion services and for treatment of abortion complications.¹³

This intervention would require improvement of the presently antagonistic relationship between biomedical and ethnomedical providers. Since it appeared from the seminars with both types of providers that the bad relationship is for a large part inspired by mutual unfamiliarity and mistrust, regular consultations between the different practitioners should be institutionalised and mediated by outside facilitators.¹⁴

Involving religious and traditional leaders

Involving religious and traditional leaders, who have been sensitised about the problems, could be a powerful strategy to help to make the problems related to abortion public and to debate underlying causes of the abortion problems. When Yoruba people are made to understand and realise the dangers of unsafe abortion, especially for their daughters, they might adjust some of their norms and rules. The leaders have the authority to appeal to men to show more understanding for the situation and needs of their wives and to parents to be more communicative with their children on sexuality issues.¹⁵

Finally

Abortion in Yoruba society is usually a strategy of individual girls and women to cope with the emergency problem of having an unwanted pregnancy. They have to manoeuvre within the constraints of society and therefore mostly do so secretly. By aborting, individual single and married women thus apply secret strategies to publicly adhere to dominant rules and norms and to safeguard their chance of a better future. Partly *because* of the wish for secrecy, abortions are often unsafe and detrimental to women's health. I think participants in this

study, who included women, men, youth and health-care providers, were made to realise that the problems could very well happen to girls and women close to them. Dominant rules may be strong, but are not static. They may change, not only under pressure of alternative norms and strategies (of which abortion is *not* an example), but also when they do not serve the interests of a society at large that is changing under influence of macro-economic and political processes. It is to the benefit of parents, school authorities, husbands, in-laws, community elders, health-care providers and policy makers that their daughters and wives do not become infertile or die from an unsafe abortion.

The role of the social researcher in applied research is to raise awareness among stakeholders at various levels and make them understand the extent and the nature of the problems, and thus as Varkevisser (1998:90) called it: to have a 'signalising function'. Signalising the complex reality of abortion for Yoruba girls and women is exactly what I tried to do in this book. Hopefully all stakeholders will seriously consider what *they* can do to protect girls and women against becoming permanently infertile after unsafe abortion or dying from this preventable cause, as Toyin most unfortunately did.

