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

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# NOTES

## Chapter 1

- 1 The first time I read about it was in the *Volkskrant*, a Dutch newspaper, of 11<sup>th</sup> May 2001: a 17 year-old girl died in a (legal) abortion clinic, due to an overdose of anaesthesia.
- 2 I chose Yoruba for the study, because in 1996 my family planned to settle in Lagos, Nigeria, the native country of my Yoruba husband.
- 3 The maternal mortality ratio (MMR), defined as 'the number of women dying of pregnancy-related causes per 100,000 live births', in Nigeria is one of the highest in the world. Okafor & Rizzuto (1994:353) report that hospital-based studies offer a MMR of between 800 and 1,500, but caution that most deliveries in Nigeria take place outside the hospitals and thus these estimates may be low. Makinwa-Adebusoye et al. (1997:155) give MMR figures of 800 for Nigeria, citing *The world's women 1995*, a United Nations report.
- 4 Their sample included 468 private and public hospitals, 50 recognised abortion providers and 14 teaching hospitals.
- 5 Compared to an annual abortion rate of 32 in the Southeast and 10-13 in North Nigeria (Henshaw et al. 1998:161).
- 6 Of the 61 listed Nigerian studies in a WHO report (1993:33-34), all but six were hospital-based studies.
- 7 Of all 2,796 girls in the study, 44% were sexually active; 3% of all girls had ever had an abortion, which means that 6% of sexually active girls had had an abortion (Makinwa-Adebusoye 1991:51)
- 8 One of those anthropologists, with whose work I am familiar, is Bleek, who did extensive work on abortion in Ghana. Bleek (1978:114) explains that the traditional abortifacients are identical with medicines employed for cleaning the uterus after birth or miscarriage and are also used in witchcraft attempts to cause enemies to abort. In another article, Bleek (1990:122) argues that abortion was most likely an exception in pre-colonial Akan society mainly because certain circumstances that now provoke abortion (which are similar to those prevailing in Nigeria) did not exist, including prolonged schooling, postponed marriages and children that are an economic burden.
- 9 See my review of this book in *Medische Antropologie* 2001:413-416
- 10 One exception that I know of, and that has inspired this study, is the extensive work on contraception and abortion in Ghana by Bleek (1976, 1978, 1981, 1987a, 1987b, 1990).

- 11 Total fertility rate is defined as the number of children that would be born per woman if she were to live to the end of her childbearing years and bear children at each age in accordance with age-specific fertility rates (Bellamy 2000:103). The total fertility rate for the whole country was still as high as 5.1 in 1998, although it had dropped since 1960 when the rate was at 6.5, and 1990 when the rate was 6.0 (Bellamy 2000:116).
- 12 Under-five mortality rate is defined as the probability of dying between birth and exactly five years of age expressed per 1,000 live births (Bellamy 2000:87).
- 13 Köbben could quite easily observe the reality of his relatively straightforward topic of adherence to taboos related to agricultural work in the rural peasant societies of the Agni and Bété peoples he studied in Ivory Coast.
- 14 It could also be argued that the peasant societies that Köbben studied could not have been as egalitarian as he described them; in every society there are societal and cultural differences, at least between age grades and sexes. In general earlier anthropologists did not pay much attention to these differences, as present-day anthropologists do.
- 15 Abu-Lughod (1986) describes in her book *Veiled sentiments* how Bedouin women and young men in Egypt, through formal oral poetry, are able to express personal feelings that would violate the society's moral code of honour.
- 16 Köbben (1955:137-138) pointed to the interest comparative anthropologists should have in describing the rate of rule-breaking in different societies who may have similar rules, assuming that the reality would always more or less diverge from the rule.
- 17 I use Rubin's broad definition of gender system as 'the set of arrangements by which a society transforms biological sexuality into products of human activity' (Rubin 1975:165).
- 18 In their respective books, the female Nigerian scholars Amadiume (1987:3-10) and Oyewumi (1997:13) oppose interpretations of African women's situation in terms of unequal gender relations, which they see as stereotypical white feminist theories. Pearce, a Yoruba scholar (1995:204) also warns against interpretations and conclusions, prompted by Western theories of gender oppression.
- 19 In Chapter 7, I will return to these rules which say that once a woman is a grandmother she should not have children anymore because she should take care of her grandchildren and that post-menopausal women should abstain because the health of their husbands may be affected by having sex with them.
- 20 Another example in which Western feminists project their own views, according to Pearce, is polygyny, which they usually condemn. However, these feminists may fail to see that in societies where official polygyny was widespread, the imposition of monogamy (by law or by religious doctrines) may actually be disadvantageous for many women. Men still have multiple relationships but marry only one while the others become the 'outside' wives. These women have no legal status and are in a very insecure position (see also Baerends 1994:33).
- 21 In her book on living with HIV in Zimbabwe, Meursing (1997:43-75) adapts the 'coping theories' of Taylor, Lazarus, Launier and Folkman for constructing a model for coping with HIV. Although coping with immediate problems like unwanted preg-

nancy and complications of abortion is different from coping with a long-term process of HIV infection and a chronic disease like AIDS, her discourse is useful for this book.

- 22 The Vietnamese women in Gammeltoft's study (1999) were likewise constrained in their choice of contraceptives by the fact that IUCD was the method of choice offered by health-service providers.
- 23 See Howson's interesting study (1998) critiquing some of the work of Foucault (1973, 1979) and followers, who consider obeying the rules (of the state or organisations) as compliance of individuals who have internalised these rules. Howson says that empirical research should pay attention to resistance and the positive motivations for seeming compliance. The same point is made by Scott (1985) in his study of hidden political resistance among peasants in a Malaysian village.

## Chapter 2

- 1 Lagos ceased to be the capital of Nigeria on December 12, 1991, when the seat of the Federal Government was transferred to the newly built capital, Abuja. Lagos is a sea-side metropolis of not less than six million inhabitants (nobody has the exact figures) and located in traditional Yoruba area. Epe LGA office statistics for 1998 gave a total population of 122,258.
- 2 Baretto et al. (1992:166) discussed methods for and problems with investigating induced abortion. He pointed to the limitations of most studies that do not elaborate on the study methodologies, including providing information to the reader on the setting, the way of establishing rapport and asking questions.
- 3 When interviewing with a survey questionnaire, 4% of women reported to have had an abortion, while with participant observation of women in the same town, he found that 53% had had an abortion. He explained the difference by the fact that in the survey approach, informants were too shocked to be asked such intimate questions by strangers, and had no choice but to lie in response (Bleek 1987a:318).
- 4 This phase lasted relatively long because I could only work part-time on the study. Since I did not have funding for the PhD study, I had to accept several consultancy assignments in Nigeria. Most of these were related to sexual and reproductive health and were useful for the present study.
- 5 Van der Geest (1998:45) used this terminology of 'natural informal conversations'.
- 6 See Box 2.1. Biodun is her real first name. The women and men who worked on the study do not mind me using their real first names. For respondents, I used pseudonyms.
- 7 When I was applying for a job in the Ford Foundation office in Lagos, I had shown them my PhD proposal. It just suited their work plan, so they funded the project phase, but not the writing of this book. I wrote a separate project report (Koster-Oyekan 2000).
- 8 Part of Epe LGA is 'riverine' area (along the lagoon and rivers) and villages are only accessible by unreliable riverine private transportation or expensive chartered boats.

This made it impossible to include them in the sample. The four districts in Epe are Epe, Eredo, Agbowo and Ejirin.

- 9 In Lagos metropolis there are several State hospitals and comprehensive health centres, numerous private clinics, LGA health centres and maternity clinics and one university teaching hospital. Epe LGA has one State general hospital, eight privately owned hospitals (six in Epe town, one in Agbowo and one in Eredo District), one mission hospital and 20 LGA clinics and maternity centres.
- 10 After obtaining the official permission of LSHMB, the medical directors and chief matrons-in-charge of both hospitals facilitated the co-operation of their staff. However, not all staff always co-operated. From my diary notes of 24<sup>th</sup> June 1998, 'There are always some nurses who look hostile when I try to explain the project to them. I just ignore them and try to smile their hostility away'.
- 11 Interviewers had been instructed to probe fully on open questions and record any additional information the respondents volunteered. Since I read the answers on a daily basis, I considered certain issues that arose regularly to be important and which then needed to be explored further through a question in the questionnaire. Examples of questions added are whether women tried to self-abort before they consulted an abortionist and whether the abortionist gave them any information on prevention of pregnancy after their abortion.
- 12 That the name was 'ANC survey' did not mean the questions only concerned antenatal or delivery care, but that interviewed women were ANC clients. The questionnaires included all issues of fertility regulation, except for current contraception use.
- 13 I am aware that *unplanned pregnancy* is a proxy for *unwanted pregnancy*. Not all unplanned pregnancies were unwanted, neither were all unwanted and later aborted pregnancies unwanted from the time the woman found herself pregnant. A pregnancy may have been unplanned, but more or less wanted by the woman, because she hoped that this would be the final motivation for her fiancé to complete the marriage obligations. If the man refused to marry her, the pregnancy became unwanted. Likewise, a married woman who got pregnant when she was not ready may redefine her situation and welcome the new child. Another possibility is that in the course of her wanted pregnancy, the circumstances changed, e.g. she found out that her husband was dating another woman, or she or he fell sick, or lost a job, which led to financial problems. The experiences in the interviews, however, show that most unplanned pregnancies were also said to be unwanted. Elu (1999:254-255), in her study on abortion in Mexico, also pointed out that the concept of unwanted pregnancy is not as simple as it would appear, although the practice of abortion is logically associated with unwanted pregnancy. She says that there is often ambivalence with respect to the longing for children, which varies with age, marital status and economic conditions. Therefore, a woman's or a couple's wanted pregnancy could become 'unwanted' when it becomes reality. In my study I asked women about their feelings at this precise moment in time, i.e. the point at which they found themselves pregnant.

- 14 Thus we asked, 'What did you do with this pregnancy?' and not 'Did you keep the pregnancy or abort it?'
- 15 This was the case only a few times.
- 16 This is unlike, for example, North Nigeria where it is difficult to find experienced interviewers who are also fluent in English, because in this part of Nigeria, the majority of girls do not attend secondary school.
- 17 As will be discussed in Chapter 3, Yoruba are generally inclined to establish their status in any type of relation or communication with other persons, by way of dress, manner of addressing others and displays of respect and disrespect. Respondents for the present study were usually of lower socio-economic status than the interviewers. I wanted to prevent what I have seen happen in many other studies I have been involved in: Interviewers, through their attitudes, making respondents too embarrassed and shy to answer.
- 18 For the period September 1998 to May 1999, we rented a two-room apartment in Epe town that served as both a house for Grace and an office for the study. The Balogun of Ijebu Epe, Alhaji Chief Apena was kind enough to let us part of his servants-quarters. This secured Grace safety and protection – a single woman renting a room on her own is not common.
- 19 The five more or less permanent interviewers in this project were Grace, Omowunmi, Comfort, Biodun and myself. I have already introduced Biodun and Grace. Omowunmi is a community midwife working in Lagos Island Maternity Hospital, and is married with two children. Comfort is a trained midwife with experience in abortion research, and is single. In Epe, Grace, Omowunmi, and I conducted the ANC and infertility interviews. In Lagos, Comfort, Biodun, and I conducted these interviews. Comfort did most of the interviews on abortion experiences in the hospital. Grace, Biodun, Mr. Latifu (a community health officer of Epe LGA health department and liaison officer between the department and the TBA association) and I interviewed the TBAs. The five additional interviewers for the community survey included three female community health officers of Epe LGA health department, Dolapo, Toyin and Yemisi. In Lagos I recruited, through networking, two women with interview experience: Ogo a nutritionist with an MSc and Kemi. Kemi, who was working in the National Museum close to LIMH had heard about this study from her friend Omowunmi and came to express her wish to be involved in it. She proved to be a very motivated, empathic interviewer. I was saddened to hear that she had died in a car accident several months after she had been involved in the fieldwork.
- 20 For this section the article of Baretto et al. was useful, in particular the section on case identification (1992:163-164).
- 21 In the interviews for the ANC survey, we asked the women whether they ever missed their period and if yes, if they used methods to 'bring back' their menstruation
- 22 In the 367 interviews of the ANC survey, 23 women (6%) reported ever having used a method, usually a drug, to bring back a missed menstruation, 5 of them (1% of all 367 respondents) said they *might* have been pregnant, but were not sure. The others said they were *not* pregnant.

- 23 In role-play the actors play the given roles without previous discussion on what the other actors will say and do. With a drama, the actors are asked to act out a realistic situation and choose their parts. The actors discuss beforehand how they are going to stage the play.
- 24 These topics were brought up during the TBA association meetings and partly varied in Lagos and Epe. Topics included postpartum haemorrhage, bleeding in pregnancy, hygiene, oedema in pregnancy and nutrition during pregnancy.
- 25 In Epe, LGA staff were Mr. Latifu and Mr. Oluwo. In Lagos, LGA health staff were Mr. Andoyi and Mrs. Tawakalitu, and from LIMH, Mrs. Lawal.
- 26 A follow-up activity of the present study, a training of the TBAs from January to July 2000, in which the same health staff as the present study facilitated, proved that the relationship between the biomedical staff and TBA was still good. They had been seeing and visiting one another since the end of the workshops.
- 27 Ilupeju Secondary School in Ilupeju LGA of Lagos metropolis was selected through networking (see Box 2.1). It is an ordinary state secondary school with about 3000 students divided over three classes of Junior Secondary School (JSS) and three classes of Senior Secondary School (SSS).
- 28 In terms of calendar dates, these sessions did not really fall within the third phase of the study, but in terms of the way the data was collected, they do. In fact, I had not really finished the project in the school in December 1998. I would have liked to continue and the students told me they would have liked to continue as well. However, the principal of the school made it impossible for me to keep on working with the students, because she required money for me to do so.
- 29 Bleek, in turn, has used the suggestions of Molnos (1968, in Bleek 1976).
- 30 Only a few students said they did not want to be part of the project, because they were Born Again Christians and did not want to hear anything about sexuality (which they equated with sex).
- 31 Students had indicated these topics, which included female and male reproductive organs, menstrual cycle and menstruation, development of pregnancy, STDs and HIV/AIDS and the prevention of STDs and unwanted pregnancies.
- 32 I had wanted Mrs. Ekundayo to interview women with complications in LUTH (Lagos University Teaching Hospital), a referral hospital, but unfortunately the doctors were on strike for months and clients were referred to other hospitals.
- 33 Two organisations, the Society for Family Health and John's Hopkins University (with a project in Nigeria), have informed me that they now make use of the information in the booklet.

### Chapter 3

- 1 Yoruba also live in parts of the adjacent Benin Republic and Togo, a country bordering Benin.
- 2 More than 200 ethnic groups live in Nigeria, each with their own language and culture. Yoruba, Ibo and Hausa are the largest in number, and together account for about 60% of the population (Larsen 1995:139).
- 3 Important reference books on Yoruba society that I used include Babatunde 1992, Bascom 1969, Buckley 1985, Fadipe 1970 and Hallgren 1988. Informants were the women, men and youth in group sessions, respondents in exploratory interviews and the secondary school students participating in a sexuality-education project (see Chapter 2).
- 4 Different Yoruba subgroups are: Oyo of Oyo and Osun state, Egba, Ijebu and Awori of Ogun and Lagos, Ife and Ijesa of Osun, Ondo, Idoko, Ikale, Idanre, Ilaje and Ekiti of Ondo state, Yagba, Igbomina and Ilorin of Kwara and Kogi states.
- 5 I had originally named this section 'religions and world-view', but was struck by the critiques of Oyewumi (1997:3), a Nigerian scholar, who commented that 'world-view' is a Euro-centric term to sum up the cultural logic of a society. The term implies that the Western world mainly perceives the world by sight. World-sense captures the conception of the world in terms of other senses, as most Africans do. I sympathise with Oyewumi's objections and follow her terminology here.
- 6 Some of the deities are known and worshipped all over Yoruba land including Obatala, the creator, Orunmila, the God of divination and Ogun the God of iron. Others are more localised and are Gods of certain rivers or mountains. Some *orisa* are more personalised, because they were living on earth as human beings before, such as Sango, the God of thunder who was a grandson of Oduduwa, while others are barely personifications of their function, such as Orisaoko, God of the farms.
- 7 This is in contrast to the situation with Ibo of Eastern Nigeria, who are predominantly Catholic.
- 8 *Aladura* churches also offer healing services for recovery of apparently incurable ailments and special services to secure economic fortune, or to ensure the favours of a man/husband or woman/wife (Haynes 1996:181-182).
- 9 A child possessed by such a spirit is called *abiku*, meaning 'born to die'. There are many ceremonies that are intended to try to keep suspected *abiku* children alive, including making *gbere*, incisions on the cheeks, so that the fellow-spirits will not recognise the child and will not call her to join them in the other world and leave the earthly parents. Maclean (1982, in Engelkens 1991:133) explains the belief in *abiku* as a 'soothing' explanation for the high infant mortality. Engelkens (1991:134) who has worked as a medical doctor in Nigeria and had personal experience with *abiku*, rather sees it as a reality, which cannot be explained by Western scientific knowledge.
- 10 Likewise Karanja's study (1994:206) among 20 educated Christian Yoruba women found that all believed in and had practiced *juju*.

- 11 Of 190 secondary school students in Lagos involved in the education project for the present study, 78% of their mothers were small traders, 18% of the students' mothers were salaried workers and only 4% of students' mothers in the project were full-time housewives. Of their fathers, 36% were in business, 8% were self-employed artisans and 26% were in a more highly qualified profession, including banker, lawyer, doctor or teacher.
- 12 A UNICEF report indicates that GNP per capita average annual growth rate was still 4.2 in 1965-80, but fell to 0.7 in 1990-97. The same report states that 31% of the population has to live on less than 1 US dollar a day, which is far from sufficient (Bellamy 2000:106). Before the 1970s, Nigeria depended mainly on agriculture for its domestic and foreign earnings. The five major export crops were cocoa, rubber, cotton, groundnuts, and palm products. Oil was discovered in Southeast Nigeria in the late 1960s (Feyisetan & Ainsworth 1996:161).
- 13 Figures on education levels attained for other areas in Nigeria: Southeast 36% no formal education, 41% primary, 23% secondary; Northwest 88% no formal education, 8% primary, 4% secondary; Northeast 83% no formal education, 12% primary, 5% secondary (Makinwa-Adebusoye & Feyisetan 1994:47).
- 14 This information is based on discussions with youths and from self-administered questionnaires with the 'fill in the sentence' question: 'After I'll have finished school I would like to ...'
- 15 DHS figures for Southwest Nigeria in 1990 on marital status: 10% of 15-19 year olds were married, 57% of age 20-24, 87% of age 25-29 and all women of 30 years and above were married (Makinwa-Adebusoye & Feyisetan 1994:47).
- 16 Marriage between blood relations was avoided, no matter how distant the relation and irrespective of whether it was through the father's or mother's line (Taiwo & Olunlade 1998:1).
- 17 Baerends (1994:24) argues that using the term bridewealth is more appropriate than using the synonym 'brideprice', because of the connotations of 'buying a wife' that the latter term has.
- 18 The quality of these ceremonial items is used to compose prayers for the success of the marriage such as, 'This is honey, although it is made by bees which sting, it is sweet. May your life be sweet (i.e. happy) as honey. Salt puts flavor into the stew. May your union be flavored with happiness. Palm oil brings a cooling effect on stew. May your life be cool. This is kola nut that produces profusely. May you increase and multiply'. (Babatunde 1992:205-206).
- 19 Compared to Yoruba, women of the other main ethnic groups in Nigeria marry relatively earlier. Ibo women in the Southeast marry on average at 18 years of age, while Hausa women in the northern regions marry at around 15 years of age.
- 20 The secondary school students were asked at what age they would like to get married. Boys reported a mean preferred age of 28.1 years, while girls reported some years lower at 25.7. The figures did not differ between Christian and Muslim students. The age at which they would like to have their first child was one year after their marriage - the main reason for marrying being to have children.

- 21 Bascom (1969:64) cited a survey of Galetti et al. in the 1950's among 776 heads-of-households in six states in Yoruba area, of whom 63% lived in polygynous unions. Orobuloye found 56% of rural Ekiti wives to be in polygynous marriages in 1975 (Caldwell et al. 1991:233)
- 22 Of the 45 Muslim students, 53% were from polygynous homes, compared to 'only' 25% of the 115 Christian students. Of the 21 non-Yoruba, mainly Ibo and Hausa, 19% were from polygynous homes.
- 23 Proverbs were collected from informants in exploratory interviews and in sessions with traditional healers.
- 24 Completed fertility is the total number of children born to a woman. This is influenced by various biological and socio-cultural factors. A woman's 'natural fertility' depends on a set of biological variables: fecundability, which is the monthly probability of conceiving; uterine mortality; duration of the postpartum period when a woman is not likely to ovulate nor conceive; and the incidence of sterility. However, cultural practises and social circumstances modify these biological variables; some examples are age of becoming sexually active, postpartum abstinence, polygyny, residence patterns, length of lactation and extra-marital affairs. Thus, completed fertility is a synthesis of biological fertility and sociocultural circumstances (MacCormack 1982:1-2).
- 25 The mean number of surviving children of mothers of the secondary students involved in the present study was 4.6. In the community survey, the mean number of children of women 40-49 years of age who had at least one child was 4.8. The women 40-49 years of age in the community survey had had a mean of 6.5 pregnancies. Thus, given the number of pregnancies 'lost' (by miscarriage, stillbirth or children who died), and the fact that most mothers of the school children would not have reached their completed fertility yet, the figures of the present study are about the same as those found by Hollos & Larsen.
- 26 Varkevisser (1973:76-77) described very similar relationships between parents and their children among the Sukuma of Tanzania.
- 27 Most (83%) of the urban secondary school students in the education project of the present study stayed in a house with only both their parents (not with an extended family).
- 28 Men have to prostrate or bow before their seniors, women have to kneel or curtsy before theirs. For seniors, one has to use the 'you' plural pronoun (*o*), instead of the singular 'you' (*o*).
- 29 Junior refers to the length of attachment to the family, not to age.
- 30 Homosexuality of both men and women is abhorred and considered a disease. It is generally known that it happens, but is always kept a secret.
- 31 Married women are not supposed to do more than play; for them, an extramarital affair is taboo. Men are allowed by custom to continue their game in a more serious manner.
- 32 Lozi adolescent girls receive education from older women about how to behave like a proper wife, including how to please their husbands sexually. During this days-long initiation, they remain in a separate room or hut.

- 33 These questions could be asked in class, but also could be written on a slip of paper, without necessarily signing a name, and then given to the facilitators. It was obvious that most of the students felt shy to ask these questions, either because it would expose their thoughts or their believed ignorance to their peers. We received most questions anonymously, on a slip of paper.
- 34 For example: Makinwa-Adebusoye (1991:46) found 44% sexual activity among urban youths aged 12-24, 3% below 15, 19% between 15-17, 61% of 18-19 and 86% between 20 and 24. A study of the Federal Ministry of Health (1994) found that 73% of urban youths aged 12-29 in 10 cities reported having started sexual activity before the age of 18. A nation-wide study in Nigeria by the Society for Family Health showed that 46% of boys and 30% of girls between 13-19 years were sexually experienced, and that the mean age for the first sexual experience was 15 years (Akinyemi et al. 1996:26).
- 35 Besides the *ọlọmọ wewẹ* and the *babalawo*, other traditional healers mentioned were: *Oniwale*, also referred to as *agbomola*, healer who saves life/people from evil forces; *Elẹwẹ ọmọ*, trader in herbs, some with speciality in children's herbs; *Alfà*, religious healer, either in the Islamic or Christian ways; *Olosanyin*, he who gazes in water or mirrors; *Dako dako*, performs circumcision of babies; *Onikola*, same functions as *dako dako* but in addition is specialised in making traditional marks on any part of the body; *Herbalist*, a generalised name for any person who uses herbs in alleviating problems; *Spiritualist (woli)*, prophet in the *Aladura* churches, may also deliver babies; and *Oloogun*, general name for traditional healer.

#### Chapter 4

- 1 In Chapter 8, the Yoruba belief that witchcraft may be the cause of infertility will be further discussed.
- 2 That too short a birth interval is still a point of gossip in Yoruba society became clear to me when I was present at a party with mainly Yoruba guests. The Yoruba master of ceremonies was going on and on making people laugh with his jokes about the Catholic Ibo of Eastern Nigeria who are used to having a child every year.
- 3 Only one group of older women had another opinion; they said that pregnancy of an unmarried girl is not stigmatising. Parents should give full support to the pregnant girl. If the man who made her pregnant denies responsibility or the girl cannot or does not want to identify the father, the girl's parents should help her to take care of the child. In most cases however, the man comes back later and claims the child. He is normally given the child, because traditionally children belong to the father's lineage. One woman told a story about her daughter who became pregnant and named three different men as the father; they all denied responsibility. She (the woman telling the story) had no choice but to accept the child of her daughter.
- 4 Only two out of 46 objected, on moral grounds.
- 5 Apprenticeship is a common way for boys and girls to learn a trade in Yoruba society – and a source of cheap labour. The parents of the apprentices have usually paid and

have signed a contract regarding the conditions of service and payments with the 'master' or 'mistress'. An apprenticeship lasts between three to five years. At the end of the training, usually a 'freedom' ceremony takes place and the apprentice gets a certificate or diploma. She or he is then allowed to set up a business of her/his own (see also Eades 1980:86).

- 6 Women of the community survey were included who had had at least one pregnancy.
- 7 Figures for the ANC survey and the community survey did not differ much in Lagos, while in Epe the figures for abortion among ANC clients was considerably higher (22%) than in the community (14%). This may be due to the fact that more of the ANC clients were from Epe town and Agbowo, a district capital, while of the women interviewed in the community survey, only about one-fifth were from Epe town and the others from rural villages.
- 8 The 410 respondents in Lagos reported to have had a total of 1,383 pregnancies, while the 509 women interviewed in Epe had 1,745 pregnancies.
- 9 As was explained in Chapter 2, we arrived at a study population of 652 women with abortion experiences (see Table 2.4). Some of these women were recruited from the three surveys done for this study, because in the course of the interviews it appeared that they had had an abortion: 157 women were recruited via the community survey, 122 via the ANC survey and 24 women via the infertility survey. The remaining 349 women who shared their abortion experiences were selected in the community and clinics of service providers solely to complete the questionnaire on abortion.
- 10 These were single women who had been pregnant.
- 11 D&C is a procedure for emptying the uterus that involves scraping the uterine lining with a metal curette (also known as 'sharp curettage'). VA, vacuum aspiration, also called 'suction curettage', can be performed with an electrical suction pump (EVA) or with a manual syringe (MVA) which is not dependent on electricity (Coeytaux et al. 1993:138).
- 12 Attempts to self-abort may have already produced some complications before the woman reaches a hospital. In non-hospitals the safety of D&C or VA is doubted because both the qualifications of the abortionists and the hygienic conditions may not be up to standard. If not done by a qualified and skilled person, D&C and VA may end in an incomplete abortion and/or perforation of the uterus.
- 13 This figure cannot be read from Table 4.5.
- 14 MVA does not require an operating theatre setting like D&C, with electricity, anaesthesia or sedation, and can be performed as an outpatient service, which makes it a much cheaper procedure. MVA equipment is available at teaching and some public hospitals, as well as at some mission hospitals. These hospitals are involved in a post-abortion care program training by IPAS (International Project Assistance Services) and IFH (International Family Health). The MVA equipment is supposed to be used for post-abortion care only. In how far the equipment is also used for procuring abortions can only be guessed at, but officially, it does not happen.
- 15 If women did not report any complications of the abortion, it does not mean that the abortion did not *have* complications. Several studies (cited in Otoide et al.

- 2001:80) have shown that there may very well be no outward complications of abortion, while later a woman may have difficulty conceiving or have an ectopic pregnancy as a consequence of her previous abortion.
- 16 Henshaw et al. (1998:160) found similar figures on percentages of abortions by private clinic providers resulting in complications.
  - 17 Applying a chi-square test found significance at  $p < .001$ .
  - 18 The question of whether the respondent had personally known a girl or woman who had died of abortion was not asked to all respondents in the community survey. This was one of the questions that were added to the questionnaire, after earlier interviews had indicated that this would be an interesting question to ask (see Chapter 2).
  - 19 This finding supports work of other researchers: Bleek (1978, 1990) for Ghana and Caldwell & Caldwell (1994) for Nigeria.

## Chapter 5

- 1 Only 17 of all 1073 abortion experiences were of either divorced or widowed women. Because their number is so small, these data have not been analysed separately.
- 2 Table 4.4 showed that at the time of the interview 83% of women were married while at the time of their abortions only 22% were married and 77% were single.
- 3 These included the community survey, the ANC survey and infertility survey (see Chapter 2).
- 4 This was a personal history in a survey and no further questions were asked, so we do not know if it was a one-time rape or a regular affair. We do not know what the mother did about her marriage; she probably had her own motivations for carrying on with it, since she did not tell the brother that his sister was raped by her stepfather.
- 5 In the questionnaire on abortion experience, it was only asked in later questionnaires if anyone influenced the woman's decision to abort. The data therefore relate to the 196 last interviews.
- 6 The national study of Henshaw et al. (1998:161) quoted in the literature review of Chapter 1, found that 27% of private hospitals provided abortion services.
- 7 Bonesetters are Ijaw/Ilaje, a Yoruba sub-tribe from Bendel State, who can massage the pregnancy out.
- 8 Abortion in a private clinic by medical staff in Nigeria is still affordable if compared with abortion in some other countries like Brazil and Mexico. Ehrenfeld (1999:378) states that abortion in a good private hospital in Mexico costs between 340 and 1000 US dollars. Misago & Fonseca (1999:224) give figures for Northeast Brazil where women have to pay between 500 and 1000 US dollars for an abortion in a clinic under medical supervision and for an abortionist outside a clinic 41 US dollars. Drugs used for abortion, mostly Misoprostol cost 21 US dollars. I do not know the income of the women, but since their studies were among poor women, we cannot expect them to be able to afford a safe abortion.

- 9 I did not find any use of Mifepristone (RU-468, 'the abortion-pill') or Misoprostol. The latter is a medicine to treat stomach ulcers that has to be put in the vagina to abort a pregnancy. It is often used in Latin American countries and described as a medical abortion method in *Where women have no doctor* (Burns et al. 1997:245).
- 10 Bleek & Asante Darko (1986:336-337) also described many of these drugs and substances to be known and used by Ghanaian women. Renne (1996:485) described their use by Ekiti Yoruba women in Nigeria.
- 11 Pick et al. (1999:300) discuss this belief in the effectiveness of ineffective abortifacients in Mexico.
- 12 These findings in Yoruba society contrast to those of Ehrenfeld's study among Mexican adolescents, where mothers are (together with boyfriends) the most influential figures with decisions concerning abortion (Ehrenfeld 1999:378).
- 13 A chi-square test revealed significant differences ( $p < 0.01$ ) in safeness of abortion by schooling status: 51% of abortions of secondary schoolgirls were unsafe, 23% of abortions of post-secondary students, 46% of abortions of apprentices and 38% abortions of non-schooling single women were unsafe.
- 14 The following anecdote illustrates the importance of a 'good' menstruation and that any irregularities can be helped by TBA treatment. During a training project with TBAs I was involved in, a TBA reported on his experiences with health education about safe and fertile periods that he had just learned about and felt confident with. It boosted all of the TBAs' morale to have learned 'modern' methods of contraception. The TBA reported: "I counselled some of my clients, about four of them. Three were infertility cases while the other one did not want to get pregnant. I explained it properly to them. I had no problem explaining it. My clients appreciated this method. At the end of the counselling one of the clients asked what she could do to have bright blood during menstruation. I answered her that I do not know of an orthodox method but gave her traditional medicines."
- 15 Two percent (2%) of post-secondary, 4% of apprentices and 2% of non-schooling women had second trimester abortions. Chi-square test is significant at  $p < 0.01$ .
- 16 In earlier abortion questionnaires it was only asked at which month the respondent aborted, not at which month she found she was pregnant. Thus in earlier questionnaires the question about reasons for any delay was also not asked.
- 17 I used the 708 abortion experiences of which women not only reported the abortion provider and methods, but *also* were asked and indicated whether they tried to self-abort before going to a provider. Thus, the total is not the 823 of all abortion experiences of single women we recorded.

## Chapter 6

- 1 I realise that the actual control of the husband and in-laws over the wife varies from marriage to marriage, but even so, each wife is still subject to the rules of being a wife.

- 2 In the community survey in Epe, 40% of women had their children delivered by a TBA and 19% in a private clinic. Of women in Lagos, 30% delivered with a TBA and 37% in a private clinic.
- 3 For all 233 experiences the figures were 79% private, 7% chemist, 6% in a room, 3% traditional, 3% self-induced and 2% public.
- 4 The medicines and substances used for abortion were explained in Chapter 5.
- 5 The stories of the three others: The first was a 29 year-old petty trader who first tried self-induced abortion by taking antibiotics. When it did not work, she went to a private hospital for D&C for which she paid just 800 naira. A 29 year-old receptionist had a vacuum aspiration of a two-months-old pregnancy for which she paid 1,200 naira; the needle of the syringe perforated the wall of the vagina and bladder. The third woman (Gbemisola) had to pay just 1,000 naira for her abortion.
- 6 As mentioned in Chapter 5, not all women were asked whether they delayed aborting after they found that they were pregnant and wanted to abort. Of 186 experiences of married women who were asked, 24% delayed aborting: 19% by one month, 5% by 2 months and just 1 person by 3 months after they found they were pregnant. Just 3% of abortions that married women had were done in the second trimester of pregnancy.
- 7 This was explained to me by informants in in-depth interviews and also found in the literature. Luchok (1993:75) stated, 'It is a taboo to reveal a pregnancy until the pregnancy is well advanced. To announce a pregnancy too soon is considered an invitation to misfortune.'

## Chapter 7

- 1 Unwanted pregnancy has been defined for this study as 'a pregnancy the woman reported not ready for when she found out to be pregnant' – see Chapter 2, and note 13 of that chapter.
- 2 See Table 3.1.
- 3 I have been unable to collect figures on the percentage of secondary schoolgirls in the general population of single women, but it won't be as high as 34%. Of all unwanted pregnancies of single women, 34% were of secondary schoolgirls, 37% of women not following any education, 18% of apprentices and 11% of post-secondary students.
- 4 Post-coital contraceptive oral methods (also called 'emergency contraceptives') can be taken up to three days after intercourse, to prevent implantation of the fertilised egg in the lining of the uterus, which, according to biomedicine is the beginning of human life. The Catholic religion in particular opposes post-coital contraception because Catholic authorities see it as an abortion rather than prevention of pregnancy. They consider fertilisation of the female egg by the male sperm as the onset of human life, unlike health professionals who regard the implantation of the fertilised egg as the start of life. In addition to oral methods (usually a large dose of ordinary birth control pills) another (biomedical) post-coital method is inserting an

- IUCD within five days after intercourse. This may inhibit ovulation, fertilisation or implantation, depending on when during the woman's menstrual cycle the pills are taken or the IUCD is inserted (see also Burns et al. 1997:224-225).
- 5 SFH receives technical support from Population Services International (PSI) Washington, and the programme itself is heavily financed by the Department for International Development (DFID), Britain.
  - 6 I learned this during a workshop I participated in to design a post-abortion care program for private practitioners. The private practitioners present indicated they were hesitant to enhance their FP activities, including counselling and selling contraceptives, because this would require extra personnel, extra space and extra time – all of which involve extra cost.
  - 7 During group discussions, the TBAs in Epe and Lagos explained that in the past TBAs did not provide methods of contraception, but just encouraged women to practise postpartum abstinence. This was because they believed that a woman did not have the right to 'interfere with the work of God'; it was considered wrong to allow children to remain in the body, i.e. to not be born. It was also risky to stop bearing children, because many children used to die in the past, and parents would never know how many would survive. Dying without any living offspring was considered the same as dying without ever having had children, a terrible fate for both men and women. The TBAs said that some modern-day TBAs give 'traditional' contraceptives since the emphasis in the country is presently on family planning, and these TBAs have responded to this trend. They reported that TBAs had known about traditional contraceptive methods from the knowledge handed down to them by their forefathers, but had not used their knowledge for contracepting purposes before, only for *juju*, magic practices.
  - 8 Taboos with *oruka* mentioned by 39 TBAs were (with in brackets the number of times the taboo was mentioned): *Oruka* should not touch the ground (9); the woman wearing it should not share a boiled egg (5), not touch a corpse (4), not wear it when menstruating (6); not eat *okro* (2); not remove it from finger (3); not share local egg (1); not share food with others (1); not eat red yam called *esuru* (1); wear it during intercourse (1); not touch *omi ogi* (water from uncooked pap) (1); not use antiseptic soap (1); not eat *asala* (a black nut) (1); not wear it when gathering refuse (1).
  - 9 Taboos associated with *aseje* include prohibitions against eating a local egg (1), dividing a gizzard (1), eating a fish called *fólo*, (which is an ingredient in *aseje*) (1), having intercourse during menses (1), telling anyone that she ate *aseje* (1) and touching a dead person (1).
  - 10 In Chapters 3 and 5 I explained that in certain poorer parts of Yoruba society, a woman is expected to prove her fertility before marriage because the family of the future spouse wants to be sure she is a wife worth the bridewealth.
  - 11 Yoruba consider the start of pregnancy as the fusion of blood of the mother and semen of the man.
  - 12 Orubuloye (1981) and Pearce (1995:199) also reported this tradition of abstinence by Yoruba grandmothers. Varkevisser (1973) reported this tradition among the Sukuma

- of Tanzania, and Oodit & Bhowon (1999:156) reported how some older Mauritian women explained they had an abortion because they already had adult children who would feel embarrassed if they had a baby sibling.
- 13 This view is common also in other societies. I came across it during my work among the Maasai of Kenya and the Lozi of Zambia.
  - 14 We asked about the opinion on modern contraceptives in an open question in the ANC and infertility surveys. In the ANC survey a total of 367 women were interviewed, in the infertility survey 69 women (see Table 7.1)
  - 15 The 1990 DHS figures on specific contraceptive use for married women in South-west Nigeria were: pills and injectables 6%, IUCD 3%, diaphragm 1%, condom 1%, sterilisation 0%, rhythm 2%, withdrawal 1% and other 1%.
  - 16 Fifteen percent (15%) of married women in the community survey were pregnant and 19% of the married women wanted pregnancy. Only 8 single women were pregnant; 6 of them with unwanted pregnancies (4 of them had tried to abort) and the other 2 were engaged and ready to be married. The 19 single women who *wanted* pregnancy were older, over 25 years, and engaged or ready to be married. 'I am ready to get married next month, so I can get pregnant now' said a 30 year-old teacher in Epe. This may point to the changing practice mentioned earlier, that in-laws-to-be now want proof of the fertility of the future wife.
  - 17 Questions inquired about the length of use, satisfaction with the method, the source of the contraceptives and whether they were used regularly or not.
  - 18 One woman using injectables for a few months complained that the injectables made her scratch her body.
  - 19 Following this line of thought, during exploratory interviews and FGDs some Yoruba reported that after menopause a woman should not have sex, because the dirt can not be washed away monthly. This is also unhealthy for the man, who can contract certain illnesses, including a certain type of *atosi*, gonorrhoea. (This would be a good excuse for a man to take a second, younger wife.) When exploring this reasoning with the TBAs involved in the present study, some, especially in Lagos, agreed, while others, in particular in Epe, disagreed. The TBAs in Epe pointed to the advantage of sex with a wife who was post-menopausal: the couple would not have to worry about pregnancy anymore and could therefore be more relaxed.
  - 20 We did not ask whether the women were using breast-feeding exclusively or whether the baby was being weaned.
  - 21 Menstrual regulation drugs including Menstrogen, Apion and Steel can indeed prevent pregnancy, but if taken without prescription and indiscriminately they may alter the menstrual cycle, cause spotting, cause menstruation to cease altogether or hormonal imbalance that leads to infertility. Gynaecosid, used in the treatment of amenorrhoea cannot work as a contraceptive, but it can cause an abortion. Purgatives such as Andrew's Liver Salt and Epsom salt cannot work as a contraceptive, although they might work as an abortifacient if taken in high dosages, by causing strong contractions. Antibiotics including Ampiclox, Ampicillin and Tetracycline may destroy the sperm cells and thus work as a contraceptive, but not as an

- abortifacient. Taken routinely as a contraceptive, they may cause resistance and render the drugs useless in case of infection. Some antibiotics may cause deformity of the foetus, gastro-intestinal irritation, skin rashes and vein problems. Alabukun and Codeine are strong analgesics that *could* sometimes work as contraceptive and also cause abortion (Source: research by Comfort Essien, commissioned for this study).
- 22 This figure is considerably higher than the 31% of the 1990 DHS figures on ever-use of contraceptives for Southwest Nigeria (Makinwa-Adebusoye & Feyisetan 1994:65).
  - 23 Yoruba women are not the only ones who gauge reproductive health by the appearance of their menstruation. In a study of acceptability of hormonal contraceptive methods, Hardon (1997:72) found that anthropological studies in many countries had identified abnormal menstruation (delay, absence or irregularity) to be considered a sign of bad health.
  - 24 The number of women out of one hundred who will become pregnant when using a specific contraceptive correctly for one year: 12 with condom, 3-5 with OCP (depending on the type of pill, e.g. progestin-only pill is less reliable), less than one with injections and 1 with IUCD (Burns et al. 1997:201).
  - 25 Injections can cause excessive bleeding and are very painful; coils can break inside the womb, cause excessive bleeding and abdominal pain; pills cause bleeding twice a month, weight gain, swollen stomach, discharge from private parts, works with your blood and causes other problems.
  - 26 The women were from different religions: Pentecostal, Roman Catholic, Mission, Moslem, Born-again Christian.
  - 27 Unfortunately, it was not asked in the first questionnaires on abortion experiences whether the woman had used any contraceptive method *before* she got pregnant. Therefore we have information on only 876 experiences.
  - 28 Chi-square test for contraceptive use before abortion / in community shows significance at  $p < 0.01$ .
  - 29 Chi-square test for contraceptive use of community women no abortion / had abortion is significant at  $p = 0.02$ .
  - 30 This interpretation cannot be read from Table 7.7.
  - 31 First the commercial drug-importing and distributing company 'Interscavon' was the sole importer of Postinor (in a pack of ten pills, for five doses, two are used at a time) from Hungary. Then Postinor-10, produced in Pakistan, reached the market through commercial channels. The Society for Family, a non-governmental organisation for social marketing of contraceptives, has recently begun promoting Postinor-2 (two pills, for one-time use) as an emergency contraceptive with a special emphasis on young persons as a targeted audience.
  - 32 A recent focus group discussion study among adolescents in Benin city, Edo State, also found high awareness of the emergency contraceptive Postinor (Otoide et al. 2001:79).
  - 33 This question was not asked in the first interviews.
  - 34 Bulut & Toubia (1999:268) reported the same for Turkey.
  - 35 Also observed by Tai-hwan et al. (1999:364) for Korean single women.
  - 36 Also identified for Mexican adolescents by Ehrenfeld (1999:374).

- 37 The earlier mentioned Postinor advocacy campaign of SFH goes along with these notions of circumstances of unprepared and irregular sex of young girls. The campaign was also inspired by the findings of the present study.
- 38 Likewise, Bleek's (1976) main conclusion in his study of birth control in a rural town in Ghana was that contraceptives were available for those who did not want them (married couples) and were kept away from those who wanted them (unmarried youngsters).

## Chapter 8

- 1 Percentages of (self-declared) infertile women who reported trying to get pregnant for less than one year ranged from 5% of infertile women in the community survey to 28% in the exploratory interviews. These percentages were 9% in the infertility survey and 14% in the ANC survey.
- 2 A research consultant collected these proverbs from community members and traditional birth attendants.
- 3 During the present study in Nigeria I had a similar self-administered questionnaire completed by 81 secondary school students in the Netherlands, 44 boys and 37 girls. The answers of the Dutch students on the same 'finish the sentence' questions were very different, as could be expected given such different sociocultural contexts. The majority of Dutch students answered that a woman or man without children probably did not want to have children, adding that they most likely had chosen for a career or wanted to keep their freedom. They reasoned that every individual has the right to choose to have children or not. Very few Dutch students thought that a woman or man would be involuntarily childless and that s/he would probably be lonely without children.
- 4 For the whole of Nigeria, the childlessness due to primary or secondary infertility was 4% as calculated by Larsen. The low figure for Yoruba may be due to biological factors, or to social factors that make infertile couples divorce and remarry. Women may also have secured children in another way than biologically (see the section on 'Coping' in this chapter).
- 5 Figures for all women, married and single, in urban (Lagos) and rural areas (Epe) interviewed in the community survey were about the same: 17% of the 283 women interviewed in Lagos and 19% of those 369 in Epe ever had infertility problems; for married women only, the figures were 24% in Lagos and 23% in Epe.
- 6 She has been using Menstrogen, indicated for menstrual regulation, as a routine post-coital contraceptive for three years, before she tried to become pregnant. This extended use of the drug might have affected her hormonal system.
- 7 Sixteen (16) women had 1 child, 11 had 2, 10 had 3, 5 had 4, 1 had 5 and 2 women had 6 children.
- 8 Infections seem to play a major role as a cause for infertility in Africa. A WHO study found that 64% of infertile women in sub-Saharan Africa had a diagnosis that could

be attributed to infection, which is about double the rate in other study regions (Gerrits et al. 1999:12). Okonofua (1996b:958) states that in Nigeria, infection is the major cause of infertility in both women and men. Infections can be due to STDs, unsafe abortion and postpartum infection.

- 9 It is striking how many of the traditional Yoruba explanations for infertility resemble those of Sukuma of Tanzania as elaborated in Boerma & Mgalla 2001, Chapters 7, 8 and 9. Other ethnic groups possibly have similar discourses. For example, *aran giniša* resemble the *nzoka* of Sukuma. *Nzoka* are snake-like creatures that live in a person's abdomen, and may cause infertility (Gijssels et al. 2001:213; Pool & Washija 2001:245; Varkevisser 1973). However, *nzoka* are believed to also possibly cause other health problems whereas *aran giniša* only cause infertility. I heard several times that *aran giniša* used to play with the foetus in the womb.
- 10 Biomedicine also considers intra-uterine fibroids as a cause of infertility. Biomedical doctors involved in the study reported fibroids as a main cause of infertility among their clients. They also reported that women are ambivalent about have a fibroid removed by surgery, because of the belief that they may come back in the next life without a fibroid which would make them unable to conceive. The TBA treatment of big fibroids by herbal medicines is intended to only shrink them, but not to remove them completely.
- 11 I described the traditional ceremony to get rid of a spirit husband in another publication (Koster-Oyekan 1999:18).
- 12 For Sukuma of Tanzania described by Allen (2001:232) and Gijssels et al (2001:212).
- 13 See Table 5.4 in which six percent (6%) of single women with an unwanted pregnancy said they did not abort because abortion was a taboo in their family.
- 14 This denial is common with stigmatising conditions, as described for leprosy patients by Varkevisser et al. (2002).
- 15 Fifty-six percent (56%) of the 153 community women with miscarriage had a D&C afterwards that was not done on medical indication. Sunby & Jacobus (2001:267) described this 'cleaning of a dirty womb' as treatment of infertility all over Africa, one that private doctors especially exploit.
- 16 Of the 118 (ever) infertile women in the community survey, 81% visited a service provider (87% in Lagos, and 76% in Epe). Of the 30 ever infertile women of the ANC survey, 87% visited a service provider in Lagos, while in Epe, 80% of the 15 women visited a provider.
- 17 I only present data on provider-utilisation for infertile women of the community survey, because those of the ANC survey may be biased towards biomedical services since more than half of the ANC clients were interviewed in the (biomedical) hospital or clinic. Even so, 35% of women with past infertility problems interviewed in biomedical ANC clinics went to a TBA for treatment.
- 18 Six women in the community survey who had problems with conceiving reported that they separated from their first husband because they could not conceive and then remarried. All but one of them had a child with their second husband. The one woman who does not yet have a child left her first husband after 25 years of marriage

- and had a miscarriage in her second marriage. Some of the women in the infertility survey also used divorce and remarriage as a coping strategy: Three women reported that they had separated from their first husband because they had no child for him.
- 19 Three out of seven women in the infertility survey who were in their second marriage, reported their first husband divorced them because of infertility. Three other infertile women had husbands who married a second wife (without divorcing the infertile wives) because they could not conceive. The husband of another woman had children with a second woman, whom he did not marry, while another husband had gotten a woman pregnant who aborted the pregnancy when he refused to marry her.
  - 20 Complications included severe bleeding, septicaemia, foul smelling discharge from the vagina, faeces in the urine, high fever and swollen abdomen, jaundice, urine or stool incontinence and/or unconsciousness.
  - 21 Of the 114 couples, 46% were infertile due to male factors, 48% to female factors, 4% to a combination of male and female factors and 2% to unknown causes (Mayoud 2001:74).

## Chapter 9

- 1 The analysis of Bleek & Asante-Darko (1986:338) for abortion in Ghana applies to many abortions of Yoruba women, 'Single and married secret love relationships can only be maintained if the pregnancy is ended'.
- 2 Misago & Fonseca (1999: 218) in their study in Northeast Brazil concluded that the increased use of Misoprostol, indicated for treatment of gastric and duodenal ulcers, as an abortifacient must be attributed to the fast spreading information on the side-effects of the drug. The drug is contra-indicated for pregnant women because it can have some uterotonic effects. Of the 2074 women whom they interviewed in the hospital where they came with complications of abortion, 66% had used this drug. I wonder whether the book 'Where women have no doctor' plays a role here (Burns et al. 1997:245). This book indicates Misoprostol for self-abortion. It advises women to go straight to the hospital when they start bleeding after they inserted the medicine vaginally. Obviously women do go immediately, because Misago & Fonseca (1999:225) found few serious complications, which *would* have occurred if women waited longer to report to the hospital.
- 3 This is the situation for many women in the world (see also Indriso & Mundigo 1999:32). See also the description of Bulut & Toubia (1999:266) for Turkey; they found that women felt abortion is a sin and they felt ashamed, but immediate circumstances nevertheless made them do it.
- 4 Seven percent (7%) of single and 4% of married women did not succeed at their attempts to abort and had the baby.
- 5 Gammeltoft (1999:245) found the same among women in Vietnam.

- 6 In an article on women's health and gender inequalities, Varkevisser (1995:188) argued likewise, 'When practices are internalised as good or inevitable by those discriminated against, they are extremely difficult to change'.
- 7 In his anthropological reflection on 'secrecy', Van der Geest (1994) discusses many examples of secrecy as a strategy in medical and social situations that threaten the well-being and honour of the strategist.
- 8 Mgalla & Boerma (2001:199) warned against giving incomplete information on contraceptives, based on a study among Sukuma of Tanzania. They concluded that 'educating' adolescents and others by providing inadequate health education and information is a step in the wrong direction. Limited knowledge about how contraceptives work appears to have made existing beliefs and rumours more scientific and perhaps more credible.
- 9 Needs and preferences vary according to the woman's marital status, her membership in a monogamous or polygamous marriage, or having no, few or many children. In the choice of contraceptive methods, women weigh a range of the believed advantages and disadvantages of certain methods. In addition to effectiveness, they consider criteria such as privacy, side-effects, convenience, secrecy, accessibility, social acceptability and cost.
- 10 The mentioned Postinor campaign of SFH (see Chapter 7, note 31) is accompanied by warnings about STDs and by promotion of condoms. In their campaign pack of Postinor, a pack of condoms is inserted.
- 11 Such a change of attitude is possible, as was also demonstrated during the workshops for this study when staff were presented with the magnitude of the abortion problems. Djohan et al. (1999:288-290) observed similar changes in attitude in their study of staff attitudes in Indonesia. When the Indonesian providers witnessed the increasing problems of unsafe abortions, they became practical in their solutions and overcame their moral and ethical objections. For example, one gynaecologist involved in the study said that when she first became a gynaecologist she was strongly against abortion. But experience and the many problems faced by her patients had completely changed her attitude. Many providers involved in Djohan et al.'s study said that it is better to help a woman than to let her go to an unqualified provider and have her come later with the complications. Cadelina (1999:319) found the same for midwives in The Philippines.
- 12 International organisations include IPAS (International Projects Assistance Services), Packard Foundation and IFH (International Family Health). Nigerian non-governmental organisations include CHAN (Christian Health Association of Nigeria), FOMWAN (Federation of Muslim Women of Nigeria) and WHARC (Women's Health and Action Research Centre). The methods they propagate for post-abortion care, using manual vacuum aspiration (MVA) to vacate the uterus, could also be used for inducing abortion. In fact MVA is a safe abortion procedure in the first trimester of pregnancy. Thus, informally, trainees in post-abortion care also learn safer abortion methods.

- 13 As a follow-up to the present study I conducted a training of 64 TBAs (most of them had been involved in the present study) to motivate them, and hone their skills for performing these tasks. After the training project, the TBAs said they felt empowered by their new skills and tasks and also more respected. The biomedical staff who were involved as facilitators said they were impressed by the abilities and qualities of TBAs (see also Koster-Oyekan 2001).
- 14 The positive experiences of this study, in which both traditional birth attendants and biomedical staff were involved, indicate that collaboration would be possible and advantageous. TBAs in the workshops for this study proved to be open to new ideas and practices. My findings support those of Green (1994:172) who wrote the following conclusion to a training project of Yoruba TBAs. 'The Nigerian healer emerges as someone quite different from the stereotype, conservative guardian of the traditional order of pronatalism and female subordination, who is quick to treat any condition that inhibits fertility while condemning family planning as not-African and perhaps unholy'.
- 15 There were some positive examples in this study in which communication and trust between genders and generations solved problems: Some men were involved and concerned, and helped their girlfriends and wives when they were faced with an unwanted pregnancy. Likewise, there were some examples of girls who confided in their mother who then supported their daughters either with having an abortion or with caring for the baby and let them go back to school. Besides the emotional and financial support, most of the thus assisted girls and women who had abortions had *safe* abortions.