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Secret strategies: Women and abortion in Yoruba society, Nigeria

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SUMMARY

Justification and methodology

Induced abortion is a controversial topic that has been ignored for a long time in many developing countries. Gradually, however, it has become acknowledged as a serious public health problem. Nigeria, where abortion is illegal unless to it is to save the life of the pregnant woman, is no exception. Establishing reliable figures on abortion is problematic, but estimates calculate that as many as 200,000 to 500,000 pregnancies are aborted annually in Nigeria and that 10,000 women die from abortion-related causes each year. Reports indicate that 35% or more of maternal deaths are due to induced abortion. Studies on abortion are, in general, hospital-based and they hardly consider women's backgrounds and their experiences with abortion.

The general study objective was to explore the sociocultural, economic and health-service related factors influencing abortion decisions and practices of Yoruba women, and to give an indication of the prevalence of safe and unsafe abortion. The study's aim was to give culturally acceptable and feasible recommendations for interventions to reduce the number of (unsafe) abortions and the morbidity and mortality resulting from abortion. Besides situating abortion in its societal context, this study also considers abortion in relation to other fertility regulation practices, including contraception and infertility treatment. Throughout the book, the societal rules, and those related to sexuality and reproduction in particular, are juxtaposed with the reality; the dialectical relationship of rules and reality is also explored. Women's decisions and actions are described in terms of 'agency' and 'coping'. In the final chapter I theorise whether or not abortion can be considered as a female strategy and resistance against certain dominant rules of the patrilineal Yoruba society that may eventually change these rules.

A premise of the study was that a public health problem such as abortion needed an applied study. A main challenge was to design a study methodology that would yield reliable information on induced abortion, a topic many researchers believed very difficult to study.

The fieldwork covered a period of three years, from 1996 to 1999, and took place in urban (Lagos town) and rural (Epe Local Government Area) areas of Lagos State in Southwest Nigeria. The study methodology was gradually developed and used methodological triangulation. The phases of data collection, (exploratory, survey and par-

ticipatory research), each had their own distinct data collection techniques. With qualitative information from the observations and in-depth interviews (with women and ethnomedical and biomedical service providers) of the exploratory phase, survey instruments could be designed. Surveys were then conducted with 652 women in the community, 356 women in antenatal care clinics and 69 women gynaecological clinics of ethnomedical and biomedical service providers. Among the women in these surveys, 303 had had induced abortion and were interviewed about those experiences, while an additional 349 other women, who were known to have had an abortion either from client files and from networking in the community, were also interviewed about their abortion experiences. A total of 652 women reported on 1073 abortion experiences. Case histories were recorded of 41 women who had come to the hospital with complications of abortion. In the third phase, the participatory phase, seminars, workshops and focus group discussions were held with women, men and youth in the community, with secondary schoolgirls and schoolboys and with health-care providers. In these group-sessions, participants discussed the findings of surveys, validated them, provided more background information and suggested how to reduce identified problems. They also received health education and information on topics of their choice.

This study did not focus on biomedical effectiveness, as most studies have tended to do, but instead paid close attention to women's intentions in using fertility regulation. Any method or measure *intended* to prevent pregnancy was considered to be contraceptive. Likewise, a woman was considered to have had aborted when she used something with the intention to abort and believed to have effectively aborted, even if it was possible that she had a (spontaneous) miscarriage or was not pregnant at all. To be able to discern all of these intentions, broad study definitions were used for abortion, contraception and infertility, and in the questionnaires filter questions were used and concepts were described thus avoiding terminology such as 'family planning' or 'contraception'.

Findings and conclusions

In spite of the societal disapproval of abortion on most grounds, both for moral reasons and especially because of the health risks involved, abortion is very common in Yoruba society, more common than any existing literature suggests. It occurs more in urban than in rural areas: Of the urban women interviewed in the community and ANC survey, 47% reported to have had at least one abortion, while only 17% of the rural women did. Seven percent of all women interviewed in the community survey had an abortion in the year preceding the survey. Most abortions occurred among single young women, and among secondary schoolgirls in particular. Of all 1073 recorded abortions, 77% were by single women, 20% were by secondary schoolgirls. Secondary schoolgirls proved to be the highest risk group because they more frequently abort, have more unsafe abortions and are over-represented in the histories

on abortion-related deaths collected in the community survey. Of the 106 histories on abortion-related deaths, 47% concerned secondary schoolgirls. The figures on abortion deaths from the literature are likely gross underestimates, because the histories of women who died from abortion 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; the family will report another cause of death instead because abortion is a source of shame for the family involved.

Yoruba society is patrilineal, which implies that bridewealth is paid to the family of the future wife. The bridewealth compensates the woman's family for the loss of her labour and gives the husband exclusive sexual access and rights to her womb, i.e. to her children. According to traditional and Islamic law, a Yoruba man can marry more than one wife. Although the rate of polygynous marriages is decreasing, still about one-third of married women are in polygynous marriages. The goal of marriage is to produce children who belong to the patrilineage of their father. The most commonly mentioned value of children is that they are social and financial insurance for the old age of their parents. The most valued virtues in children are those of obedience and demonstration of respect to parents, elders, leaders and teachers. Traditionally there is little communication on sexuality between parents and children and often children do not have adult confidants on these matters. Peer-groups are therefore the major source of sexual information and reference for youth.

Yoruba highly value formal education, which they consider the avenue to success in life. The cost of educating children is a heavy strain on most families because of the poor economic situation of the country: An ever-increasing number of families are finding themselves in financial problems. The pressure on children to finish their education and not disappoint their parents is big; it is especially a strain on daughters, for parents are usually more interested in educating their sons. Yoruba girls now marry relatively late, at 20 years of age or later; they postpone marriage while they pursue a higher education or set up a business of their own.

Dominant rules dictate pre- and extramarital sexual abstinence for women. If individuals go against the societal rules they will try to do so secretly, because exposure would cause shame. Every Yoruba detests and will try to prevent *asiri*, 'embarrassment caused by revealed secrets'. The traditional worldview with its strong belief in evil spiritual forces and in the continuing influence of deceased ancestors still influences Yoruba's perception of causation of events, although such beliefs are now 'diluted' with Islam and Christianity. The spiritual powers help to maintain norms and values, because opposing them could mean that the powers will punish the person with misfortune, for example infertility, which is one of the worst punishments, especially for women.

Because the socio-economic conditions of single and married women differ, their ways of coping with an unwanted pregnancy are discussed separately in this study. For single girls who are still in school (primary, secondary, university or in an apprenticeship), the motivation for aborting an unwanted pregnancy was mostly that they did not want to end their education. Disclosure of the pregnancy would mean dismissal

from school and most probably the end of their education, because their parents might force them to marry the father of the baby and/or stop paying for any further education. For the rest of their lives, they would have to bear the shame of a discontinued education and/or a premarital child. Girls and single women not in school often had economic motivations for not wanting a pregnancy, as they saw their plans to pursue a career or further schooling thwarted. Sometimes they did not want to be forced to marry the father of their baby because they did not see him as a husband. Younger girls especially feared the reaction of their parents.

The reasons why a pregnancy was unwanted for married women, even though Yoruba culture is pronatalist and dictates that all children conceived in marriage are wanted, was that the pregnancy was poorly timed. Either these women were pregnant too soon after the previous baby, or a pregnancy compromised their business or career opportunities. Some women thought that they had enough children and could not afford more children. Since women in Yoruba society bear the brunt of the financial and practical care of the children, a pregnancy is more often unwanted for women than for men. About half of the married women in this study did not involve their husbands in their abortion – indicating that he might not have known about it and probably would not have agreed.

Abortion in Nigeria is illegal unless it is to save the life of the mother-to-be. Therefore, public hospitals only perform (legal) abortions for health reasons. The illegality does not keep abortion providers from offering their services; they abound. Women can go to private clinics and hospitals, back-street abortionists, chemists and traditional healers for an abortion. These providers perform dilation and curettage (D&C), vacuum aspiration (VA), give injections, drugs, herbal drinks or insert something in the vagina or uterus. In quality private hospitals, a D&C costs a minimum of 1500 naira (at that time, the equivalent of 16 US dollars, about one-fifth of a average government worker's monthly wages). All other providers' abortion services, including those of sub-standard private hospitals and clinics, are cheaper. Three-quarters of the unmarried and 80% of the married women had their abortion in a private clinic, sometimes after having unsuccessfully tried to self-abort by taking medicines. A third of secondary schoolgirls had tried to self-abort (N=179).

About one-third of the 1073 abortions we recorded were unsafe. Criteria used for a safe abortion in this study were 'an abortion of a first trimester pregnancy in a private or public hospital by D&C or VA, without any preceding attempt to self-abort'. All other abortions were labelled unsafe. Of course, we cannot conclude from these figures what the total rate of unsafe abortions is, because the group of women who most likely had unsafe abortions is missing: those women who died. From the 106 recorded histories on women dying after abortion, 95% had been unsafe according to the study criteria. Young girls, and secondary schoolgirls in particular, were the most vulnerable groups: 47% of girls below 20 years of age, and 51% of the secondary schoolgirls who aborted had unsafe abortions.

Girls and women (and boys and men) know which abortionists and methods are relatively safe and which are unsafe. Therefore, a lack of knowledge does not seem to be the reason for resorting to unsafe abortions. The two main reasons for going to an unsafe provider or using an unsafe method appear to be the wish for secrecy and the lower cost: All unsafe methods and providers are more private and cheaper than safe methods. Women emotionally cope with the higher risk by focusing on the stories of girls and women who successfully aborted using unsafe methods. They avoid thinking about the stories of girls and women who died after using them, even though such stories abound. Schoolgirls and young single women usually are most in need of a secret abortion. Moreover, they have the least resources and still have to find their way towards an abortionist. Therefore they are most prone to unsafe abortions.

The decision to abort is usually made by the girl or woman herself, but others often help her to decide which methods to use, accompany her to the provider and assist in the payment of the abortion. Girlfriends are mostly involved in the decision of which method to use to abort and accompany the girl or woman to the abortionist. Partners often help to pay for the abortion, that is, if they know their girlfriend or wife is pregnant and agree to the abortion. The partners of single women are particularly likely to agree with a woman's decision to abort, because they too would not want an unplanned pregnancy and a forced marriage, which would thwart their career and/or educational plans. Very few girls and single women involve their mother or father in their decision to abort; parents are the main persons they want to keep their abortion hidden from both out of shame and because parents may prevent them from aborting.

When complications occur after abortion (13% of all recorded experiences resulted in complications, and 24% of unsafe abortions did), single girls and women usually are at a disadvantage compared to married women. All girls and women know that complications after abortion are dangerous. When a girl or single woman develops complications, her confidants (girlfriends or partners) are usually not around. She does not have money to go to a hospital, even if her physical condition would allow her to go by herself. She may decide to confess everything to her mother, but many girls were found to continue to hide the cause of their health problems. Parents only heard what happened to their daughter from the doctor in the hospital. This delay in seeking adequate treatment of complications aggravated the problems. Married women who develop complications can, at least initially, pretend they have had a miscarriage which will arouse everybody's empathy and help. Not disclosing a pregnancy until it starts to show, even sometimes to husbands, is normal in Yoruba society.

A central question in this book is why so many women do not prevent an unwanted pregnancy by using effective contraception. Some researchers have suggested that women might prefer abortion to regular contraception as a method of birth control. Yoruba societal rules oppose the use of contraception for single as well as married women. Only with approval of her husband is a married woman allowed to use it, and many husbands do not like to give permission to their wives or even discuss it with them. A striking finding was that contrary to common beliefs that the contraceptive

use is low (the 1990 DHS figure on contraceptive use is only 15%), the majority of women in the present study who did not want to become pregnant *tried* to prevent it. This is an obvious sign of their agency in their opposition to dominant rules. However, for several reasons, including fear of side effects, wish for secrecy and non-accessibility of services, many users do not use modern contraceptives. They use many types of other less effective or totally ineffective contraceptive methods, which I categorised as natural, traditional, home methods and modern drugs that are not indicated for contraception. The last category, the inappropriate drugs (for example antibiotics, purgatives and menstrual regulation drugs), was especially popular among urban single girls and women: 23% were using these often dangerous but relatively easily accessible drugs. Women and men are sceptical of modern contraceptives because these have ambiguous connotations. On the one hand, Yoruba believe they are effective, but on the other hand they are feared because these methods may be *too* effective and impair future fertility. Moreover, public family planning clinics are not accessible to girls and single women, and the married women for whom they are intended generally do not like these clinics because their services are not confidential, even though most women would want to secretly use contraceptives.

Yoruba are preoccupied with fertility. Infertility is a stigma and highly feared because of its negative social consequences, especially for women. Infertility of a couple is a reason for the husband to marry another wife, and for divorce by either husband or wife. An infertile woman may become a social outcast. Because of the fear of infertility, women make decisions that may be detrimental to their health, including not using effective modern contraception. Paradoxically, these decisions dictated by fear may cause their fear to become reality, when women develop secondary infertility after aborting an unwanted pregnancy.

Experiences with abortion show that for women, abortion is usually a secret strategy of coping with the stressful situation of having an unwanted pregnancy. It is not a preferred, alternative way of birth control, as some researchers suggested. Abortion serves to hide a pre- or extramarital relationship, to be able to continue schooling or a career, to prevent being forced to marry and to guard against the financial problems that an additional child would bring. Abortion is a strategy of individual women to prevent embarrassment and to publicly adhere to dominant rules and values, when circumstances have made them (often secretly) violate these rules. Abortion therefore is usually not a form of female resistance against certain rules, and definitely not of females-as-a-group resistance. The patrilineal society divides women as far as sexuality and reproduction is concerned and forces them to compete with one another. Thus, abortion is 'just' an individual strategy. Because women's agency is severely conditioned and constrained by the socio-economic and service context, they often do not reach the goal of their strategy, i.e. solving their (hidden) problem by having a secret abortion. Tragically, they may end up with health complications and social repercussions instead.

Recommendations

Legalising abortion would contribute to making more abortions safe, but legalisation is a long process and strictly speaking, not a precondition for safe abortion, though it does facilitate it. To begin with, interventions could be implemented to make more abortions safe in illegal circumstances and to prevent morbidity and mortality resulting from abortion. Girls and young women, secondary schoolgirls in particular, are the high-risk groups and therefore they (and their male counterparts) need priority attention. Women should receive improved contraceptive education, counselling and services, in which attention is given to women's concerns and preferential criteria for contraceptives. Warning campaigns should be organised against dangerous contraceptive methods and unsafe abortion methods and providers. Married women could be reached through regular maternal and child health clinics, girls and single women (and their male counterparts) through special campaigns and youth-friendly clinics

Improved access to high quality post-abortion care could prevent abortion complications from worsening. More attention should be given to treatment and prevention of infertility, and such services should be integrated: improved STD treatment and contraceptive services could prevent many infertility problems. In contraceptive promotion this added advantage of preventing infertility and STDs including HIV should be highlighted and will facilitate acceptance.

Ethnomedical and biomedical services could profitably co-operate in educating community members about abortion and the prevention of (unsafe) abortions. Ethnomedical service providers are highly used and respected in town and rural areas. They, together with other traditional and religious leaders, have the authority to discuss the unequal gender and generational relations with husbands and parents. This is vital, as such relations are disadvantageous to girls and women and, as this book has illustrated, may result in severe health problems or death. Recommendations made by participants in group-sessions for this study show that when parents, husbands, adults and teachers realise the extent and nature of the problems related to abortion, they might gradually adjust some of the traditional rules and norms that are injurious to the health of their daughters and wives.