“I really wanted to abort”

Desire for abortion, failed abortion and forced motherhood in South-Western Nigeria

Names: Ayomide Oluseye¹, Dr. Philippa Waterhouse², Prof. Lesley Hoggart³

¹ The Open University, Walton Hall, Faculty of Wellbeing, Education and Language Studies (WELS), Milton Keynes, United Kingdom, MK7 6AA. ayomide.oluseye@open.ac.uk

² The Open University, Walton Hall, Faculty of Wellbeing, Education and Language Studies (WELS), Milton Keynes, United Kingdom, MK7 6AA. philippa.waterhouse@open.ac.uk

³ The Open University, Walton Hall, Faculty of Wellbeing, Education and Language Studies (WELS), Milton Keynes, United Kingdom, MK7 6AA. lesley.hoggart@open.ac.uk

Corresponding Author: Ayomide Oluseye

Email: ayomide.oluseye@open.ac.uk

Address: The Open University, Walton Hall, Faculty of Wellbeing, Education and Language Studies (WELS), Milton Keynes, United Kingdom, MK7 6AA

Abstract: 200 words

Word count: 6,374 words
Abstract

Continued pregnancy after an abortion attempt is a likely outcome in countries where unsafe abortions prevail. Yet there is a paucity of literature on the consequences and implications of failed abortions. This study explored young women’s abortion decision-making, their experiences of failed abortion and its consequences in South-Western Nigeria. It presents findings from semi-structured interviews conducted with 14 women who had become unintentionally pregnant as unmarried teenagers, desired abortions, yet became mothers. Whilst the fear of the stigma associated with young unmarried motherhood gave rise to participants’ desire for abortion, restrictive abortion laws influenced their experiences and abortion decision-making. Participants who attempted an abortion failed and were forced to carry their unwanted pregnancies to term. They then experienced continued discrimination, forced motherhood, and a rejection of maternalism. Their experiences are analysed as responses to the complex interplay between social norms, abortion restrictions, stigma and forced motherhood. The paper makes a case for improving women’s reproductive autonomy in decision-making, - highlighting the social and mental health consequences of restricted access to abortion, and reinforce the importance of taking a holistic approach to addressing the sexual health of young women, by focusing not only on physical health but also on ensuring wellbeing.

Keywords: Failed abortion, unsafe abortion, forced motherhood, unintended pregnancy, Sub-Saharan Africa
1. Introduction

Worldwide, 48% of pregnancies are unintended (Bearak et al., 2020). Unintended pregnancies are often also unwanted, and such pregnancies may have significant impacts on women’s mental and emotional wellbeing, hence the desire and need for abortion (Biggs et al., 2017). Between 2015 to 2019, 73 million abortions were estimated to occur annually, suggesting a 61% increase in the percentage of unintended pregnancies ending in abortion since the 1990s (Bearak et al., 2020). Bearak et al. (2020) also noted a 50% increase in abortion procurement for unintended pregnancies in countries that restrict abortion. Where abortion is illegal, women are likely to lack access to adequate information on how to safely terminate unwanted pregnancies (Oyeniran et al., 2019). The incidence of failed termination of pregnancy (here defined as continued pregnancy after an abortion attempt) is also likely to be higher among unsafe abortions as abortion services vary by provider-factors such as the experience of the provider (Akande et al., 2020). As such, many women living in countries with restrictive abortion laws, experience failed abortions, are forced to continue with unwanted pregnancies, and consequently experience what has recently been conceptualised as ‘forced motherhood’ (Casas, 2019).

Studies conducted in high-income countries have shown that women who experience forced pregnancy and motherhood may encounter adverse socioeconomic outcomes, have a higher risk of mental health problems and be more likely to reject maternalism (i.e. the ability to have and show maternal instincts) (Due, 2016); that women are expected to accept (Barber et al., 1999; Biggs et al., 2017; Foster et al., 2018). Currently, there is a paucity of literature on the consequences of failed abortions for women in low and middle-income countries (LMICs): Nigeria is one such country.
2. Nigerian Context

According to national survey data, 57% of women aged 15-49 years in Nigeria become sexually active by the age of 18 years; yet, approximately 97% of women aged 15-19 years do not use contraception (National Population Commission (NPC), 2019). These statistics reflect the stigmatization of pre-marital sexuality that serves to limit young people’s access to sexual and reproductive health (SRH) services. A 2018 qualitative study exploring bias in contraceptive information to young women in South-Western Nigeria illustrates this as well; one of the study participants, a pharmacist, noted that she would not provide contraceptive information to female adolescents because “they are not supposed to be having sex” (Sieverding et al., 2018, p.25). Other studies also highlight how community members deliberately withhold SRH information from young people, provide misleading information on sexual issues and reinforce negative attitudes towards the provision of SRH services for young people (Envuladu et al., 2017; Omideyi et al., 2011). These cultural norms against premarital sex block access to SRH information, therefore limiting women’s reproductive autonomy, and causing high rates of unintended pregnancies.

In Nigeria, women are socially expected to uphold moral values by remaining virgins until marriage (Familusi, 2012); thus, pre-marital pregnancies carry negative social consequences. Studies show that unmarried young women who become pregnant, sometimes experience public humiliation, educational disruptions, increased economic hardship and rejection by their parents (Onyeka et al., 2011; Oyeniran et al., 2019). These negative societal overtones suggest that pre-marital pregnancies are likely to be unwelcome, creating a demand for abortion among young unmarried women.
Abortion is considered a felony in Nigeria (except in a life-threatening situation) which carries a seven-year jail term for the woman; a three-year jail time for any accomplice; and a 14-year term for the person who performs the abortion (Akande et al., 2020). Underlying this restrictive abortion legislation are social, cultural and religious overtones. Kumar et al. (2009) hypothesize that abortion challenges the gendered expectations of female bodies (for reproduction and motherhood), asserting women’s autonomy in a threatening way. Within the Nigerian context, access to abortion can also allow women - particularly young women - to avoid the social sanctioning of unmarried pregnancy and motherhood (Oyeniran et al., 2019). On these grounds, abortion is stigmatised as it violates the ideals of womanhood, and abortion stigma is used to control women’s reproductive choices (by limiting access to safe abortion services, consequently imposing motherhood on them). This interplay between gendered expectations and abortion stigma shows how the traditional view of women is used to marginalise and limit access to reproductive healthcare services like abortion.

Although national data on abortion in Nigeria are unavailable, indirect estimates based on nationally representative data indicate an abortion incidence of 45.8 abortions per 1,000 women of reproductive age- a significant proportion of which are unmarried young women (Bell et al., 2020). As these (clandestine) services often come at a financial cost, unmarried young women with low income may experience difficulties in accessing ‘safer’ clandestine abortion services and resort to unsafe practices (Bell et al., 2020). Thus, the legal constraints, paired with minimal access to sexual and reproductive health services mean that young women in Nigeria lack access to reliable information on how to terminate an unwanted pregnancy safely.
Previous studies on abortion in Nigeria have focused on women’s abortion decision-making, complications of abortion, and the experiences of induced abortion (Bell et al., 2020; Omideyi et al., 2011; Oyeniran et al., 2019). In Nigeria, little is known about the social and wellbeing consequences of women who experience failed abortion and are forced to continue with an unwanted pregnancy. Younger women are particularly vulnerable to failed abortions and forced motherhood as they are more likely to be economically dependent and less likely to be empowered to make reproductive decisions (Bell et al., 2020). This paper addresses a gap in the literature by exploring young women’s experiences of failed abortion in South-Western Nigeria. Specifically, the study examines: firstly; how socio-cultural circumstances influenced young women’s decisions around unwanted pregnancy; and secondly: the consequences of failed abortion and resultant forced motherhood for young women’s identity. Underpinning both these issues, in different yet related ways, the concepts of stigma, social death, and having a stigmatized identity, provide a powerful interpretive lens.

3. Conceptual underpinning

Králová (2015) states that social death involves a series of losses, some of which include: a loss of social connectedness, social identity, social engagement, and interaction. These losses can reinforce social exclusion and disconnect individuals from their social world. Although the concept of social death is widely used with experiences of illness and dying (see for example; Seale, 1998), it is consistent with stigma which Goffman describes “as an attribute that is deeply discrediting…that reduces individuals from whole persons to tainted, discounted ones” (Goffman, 1963, p.13). According to Goffman (1963), people often make assumptions of how others ought to behave based on normative societal expectations. When an individual’s behaviour falls short of
the normative expectations, they acquire a spoiled identity which leads them to experience stigma (Goffman, 1963). Based on this premise, this paper will examine the competing stigmas of pre-marital pregnancy, young unmarried motherhood, and abortion. Link and Phelan (2001) focuses on the dynamics embedded in the relationships between society and stigmatised individuals, and how this contributes to the reproduction of social inequalities. In their study, they describe how components of stigma, such as labelling, stereotyping, and discrimination, are used to reinforce isolation and exclusion among individuals with a spoiled identity. We will draw useful insights from these stigma theories to examine participants’ experiences of labelling, stereotyping, and discrimination. We will also use participants’ narratives to show how stigmatisation may lead to social death. Here, the social death of pregnant unmarried young women arises from the discriminatory socio-cultural practices, marginalisation, and exclusion that they face due to their inability to terminate their pregnancies.

4. Methods

4.1 Study setting and sampling

This present study was carried out among unmarried young mothers in Mokuro, a rural town in the Eastern part of Ile-Ife, Osun State, South-Western Nigeria. Mokuro has an estimated population of 259,700 with its predominant economic activities located in the informal sector (such as farming, and trading) (Ajala & Olayiwola, 2013). The data gathered for this paper stem from a larger study that included 24 women aged 18 to 30 years old who gave birth to their first child between the ages of 15 and 19 and were unmarried at the time of birth.
The sample was initially recruited through purposeful sampling and information sheets were distributed at community centres, hospital settings and school halls. Snowball sampling was further used where initial participants were asked to give study details to others who may be interested in taking part. Those who agreed to participate were given information on the purpose of the study, and an interview was scheduled for a date and location selected by the participant. Interview locations ranged from empty rooms in community halls to empty classrooms in community schools. This larger study aimed to explore the experiences of pregnancy and motherhood of young mothers in South-Western Nigeria.

This paper considers a sub-sample of the study’s overall sample: 14 women who spoke of wanting to abort the pregnancy of their first child. Of these women, 10 reported that they attempted abortion, and 4 reported that whilst they wanted an abortion they did not attempt to abort (Figure 1).

Figure 1: Participants included in this analysis compared to the overall study sample

4.2 Data collection

This study used semi-structured in-depth interviews to explore the lived experiences of unmarried young mothers in Nigeria. The first author conducted these interviews over nine weeks from November 2018 to January 2019. Important interviewer characteristics to note include: gender (female), nationality and ethnicity (Nigerian from the same ethnic group- Yoruba- as participants), and occupation (doctoral candidate at a U.K. higher education institution).
Three interviews were conducted in English while eleven interviews were conducted in Yoruba. Semi-structured interviews were used to elicit responses on a range of topics related to young women’s reaction to their pregnancies, societal attitudes towards pregnancy, pregnancy resolution and experience of motherhood. Basic socio-demographic information was also collected. Interviews lasted between 30-60 minutes, were audio-recorded, (for which consent was gained before the interview) and transcribed. Participants were compensated with vouchers as an appreciation for participating in the study.

4.3 Ethical considerations

Prior to the interview, each research participant was given an information sheet, and written consent from participants was obtained. To ensure confidentiality, specific details that might reveal the identities of participants were removed and transcripts were anonymised. Pseudonyms are used to ensure anonymity. Permission to audio-record the interviews were also obtained from participants. Ethical approval was obtained from the Open University Human Research Ethics Committee (HREC) (ethics code: HREC/2290/). The research also followed guidelines from the “National code of health research ethics” of Nigeria (Yakubu & Adebamowo, 2012).

4.4 Data analysis

All interviews were transcribed by the researcher in English. The transcripts were then proofread and discussed with professional translators to ensure that translated transcripts accurately described participant’s narratives. Transcripts were also cross-checked with audio recordings to check for accuracy. This paper focuses on retrospective narrative accounts relating to factors that influenced the desire for abortion and the consequences of failed abortion among 14 young women.
in South-Western Nigeria. The data were analysed using Interpretative Phenomenological Analysis (IPA). This is a method of analysis that begins with coding the transcripts, identifying patterns within transcripts and developing emerging themes (Alase, 2017). Using this approach, the authors first identified the main themes, then sought to understand these themes through the lens of stigma and social death. This provided a theoretical analysis of the data and an in-depth understanding of participants’ narratives. Any uncertainties around meanings were discussed and resolved amongst all three authors.

4.5 Characteristics of the analytical sample

Table 1 displays each participant’s socio-biographic details. Of those included in the analysis for this paper, six women were aged 15 years at the birth of their first child, four 16 years, two 17 years and two 18 years old. Three young women reported attempting an abortion once while seven attempted to abort multiple times. At the time of the interview, the women ranged between the ages of 19 and 30, with their first-born child ranging between the ages of 3 and 15 years.

<table>
<thead>
<tr>
<th>Table 1: Young mothers’ socio-biographic details</th>
</tr>
</thead>
</table>

5. Results

Four main themes were identified from participants’ narratives on their abortion decision-making process, experiences of failed abortion, and forced motherhood. These are: dealing with a spoiled identity, abortion barriers, abortion attempts, and consequences of failed abortion. The results are presented chronologically to retain a sense of women’s pathways. The results section begins by analysing the women’s reasons for wanting an abortion, then discusses the women’s attempted
abortions; and, finally, considers the consequences of this trajectory for their new – unwanted – identities as mothers. Supporting quotations from the study participants are indicated by their pseudonyms, followed by the time of their pregnancies and age at interview.

5.1 Dealing with a spoiled identity

All interviewees reacted to their positive pregnancy test with shock and described them as unplanned. For these young women, becoming pregnant was not an ideal life choice due to the existing societal views about pre-marital pregnancy and motherhood. Thus, they described pregnancy as an event that could disrupt their future educational trajectory and the achievement of their aspirations.

I was shocked and worried because that kind of thing is a disgrace here, nobody will support you. In this area, they think that once you are pregnant, your future is ruined, you cannot attain anything in life...So I knew it could affect my education and plans.

Abiodun (pregnant at 18 years, interviewed at 24 years)

In the above narrative, the study participant details how an unmarried pregnant young woman can expect to experience a loss of identity, status, and social connection due to the stigma associated with early pregnancies. These fears of exclusion and stigma were important considerations in abortion decision-making. Partner reaction also reinforced the desire for abortion. In this study, all participants’ partners denied responsibility for their pregnancies and this consequently led to the dissolution of their relationships. In Nigeria, unmarried young women who become pregnant out of wedlock and whose partner do not claim responsibility for their pregnancies can expect to face double stigma (Familusi, 2012). Thus, the unwanted status of being pregnant was often riddled with anxiety and fears. In these socio-cultural circumstances, all fourteen young unmarried women
contemplated and spoke of wanting an abortion in attempts to retrieve their identities as non-pregnant women.

5.2 Barriers to abortion

Seeking to return to a previous – non-pregnant – state was, however, fraught with difficulties. Due to the perceived risks and stigma associated with illegal abortion in Nigeria, many participants spoke of procuring an abortion as a ‘gamble between life and death’. Accordingly, four out of the fourteen young mothers did not attempt an abortion. One study participant, for example, felt that the pregnancy would put an end to her hopes and ambitions, yet her fear of dying over-rode this:

*I had hopes of how I wanted my life to be and I knew this pregnancy would put an end to it. I knew that I would be expelled from school, people would make jest of me, and my parents would beat me and send me away. So, I really wanted to abort but my friends and family told me that if I use anything to abort the pregnancy, I would die and since I had never had the experience, I believed them….*

Bose (pregnant at 15 years, interviewed at 30 years)

Our interpretation of Bose’s narrative is that she can expect to experience stigma and discrimination as an unmarried mother, yet her fear of abortion-related death is preventing her from having an abortion. Also, by stating her belief that she would die if she has an abortion, Bose’s narrative shows how community members (such as friends and family) draw on prevailing attitudes towards abortion to control and limit young women’s access to reproductive health services. This shows how pregnancy resolution is not solely based on the decision of the woman but also incorporates social and legal constraints which affect a woman’s ability to transform a choice into the desired outcome (in this case, abortion).
The other major barrier to abortion identified in the data was the strength of prevailing socio-cultural norms that stigmatise abortion and both sustain and reflect the illegality. Common manifestations of abortion stigma emerged in this study as some participants framed abortion as ‘murder’ and ‘a sin’ which had negative repercussions such as ‘going to hell’. One study participant, for example, was about to begin her university education when she discovered that she was pregnant. She explained how upon the discovery of her pregnancy, she had wanted an abortion because she felt that it would affect her university education and future. However, she eventually decided against abortion due to her religious beliefs:

I really wanted to abort because I did not want anything to come between my education and my future, but I was afraid that God will punish me because I killed a baby. You know abortion is a sin...it was not easy at all, I had friends who had aborted, and they could have helped me with an abortion but I was just afraid of offending God and going to hell.

Kike (pregnant at 16 years, interviewed at 20 years)

For this young woman, and other participants, it was thus not only the non-availability of abortion services that limited their access to abortion, as religious and socio-cultural beliefs also had significant influences on their decision to terminate their pregnancies. Nevertheless, study results show that despite the risk and the stigma involved, ten of the young women attempted an abortion.

5.3 Abortion attempts

Participants drew on diverse sources of information, service providers and methods, illustrating the various pathways to attempted abortion that young women in Nigeria negotiate. All ten young women initially attempted self-medication using medication obtained from the medicine cabinets
(within their homes), because they did not have the financial resources to obtain abortion. Following initial failed attempts, several of the participants went on to make multiple efforts to abort using different forms of ‘medication’ or attempted surgical interventions. For instance, Tanwa, who was struggling financially, and had been abandoned by her partner, tried to abort by ingesting large quantities of locally made concoctions, followed by a variety of medications which she believed had abortifacient properties:

*I mixed kaun [cooking potash] with lime and drank unimaginable quantities of these things but the pregnancy refused to abort. I later met a Nurse who mixed some medications for me. I think the name was Arthrotec [which contains diclofenac and misoprostol]. She mixed it with Quinine [an anti-malarial]. She said I should take everything at once so that it can be quick. I drank it with dry gin, but the pregnancy did not abort.*

Tanwa (pregnant at 15 years, interviewed at 30 years)

Tola who was estranged from her parents and became homeless after her partner denied responsibility for her pregnancy, further explored the option of a surgical abortion following multiple failed medical abortions:

*When the medications did not work, I went to a hospital to try and abort the pregnancy, they said I should bring some money, but I did not have it. By the time I gathered the money, they said that this one is already a child and that if there are complications, it will become a criminal offence, so they said that they could not help me. I went to three more hospitals after, but they also said the same thing. I tried other medications, but they did not work. After this, I decided to leave it and just accept my fate... It was not like I wanted to be a mother; it was just that everything I tried [to end the pregnancy] just refused to work.*

Tola (pregnant at 18 years, interviewed at 26 years)
The various obstacles (such as financial constraints, the illegality of abortion and medication misuse) which limit young women’s agency in procuring abortion are clear from their narratives.

When asked why they tried multiple times to abort, Tanwa said that she ‘felt that the pregnancy will be the end of her life’ due to the social isolation and financial difficulties that she was experiencing while Tola noted that she felt her life was ‘doomed’ because people in the community kept saying that she ‘will not amount to anything.’ These statements show how study participants were aware of the consequences of their spoiled identities and self-worth lost due to stigma. Participants’ multiple attempts in trying to procure an abortion thus indicate the diverse pathways and desperation involved in wanting to avoid social death and the stigmatising experience of young unmarried motherhood. However, the abortion ban and limited financial resources to procure an abortion meant that study participants experienced failed abortion attempts and were forced to continue with an unwanted pregnancy.

5.4 Consequences of failed abortion

Study results show how failed abortion affected all levels of study participants’ lives. This section will show how the legal constraints on abortion can have significant social and wellbeing consequences by predisposing unmarried young women to stigma, discrimination, and forced motherhood. It will also show how these experiences of a spoiled identity resulted in a rejection of maternalism among study participants.
5.5.1 Experience of stigma

For the study participants, their continuing pregnancies served as a visible marker of stigma. Participants described how individuals within their larger society associated negative traits with their pregnancies and stereotyped them. One participant said:

*People really made fun of me when I got pregnant. They called my pregnancy a shameful pregnancy and so many of my friends stopped talking to me because they felt that I was immoral. I could no longer go to school, church or parties because everywhere I went, they treated me like I was rotten. They told me that my life was over...*

Lola (pregnant at 17 years, interviewed at 20 years)

A similar pattern of being mistreated because they had a *shameful pregnancy* was seen across all participant’s narratives and illustrates how young women in the study felt that they were ascribed a stigmatising label because being a young unmarried mother is counter-normative. This experience of labelling, stereotyping and becoming socially distanced from previous social activities and relationships highlight characteristics of stigma and social death wherein individuals who are considered less human, experience marginalisation within society (Králová, 2015; Link & Phelan, 2001). Study results show that participants’ fears of the negative consequences associated with the continuation of their unwanted pregnancies were apt. Their spoiled identities did limit their future trajectories. In this study, participants spoke of being expelled from school and being denied employment opportunities due to their identities as pregnant mothers.

*One time I wanted to learn and work as a hairstylist so that I can support myself and my baby, but when she [employer] discovered that I was pregnant, she said that she cannot accept someone like me. I also tried to learn how to be a salesgirl for people that sell*
foodstuffs, but they too also said that they cannot accept me because they felt I was wayward. Everywhere I went to look for work, it was like people were judging me.

Anu (pregnant at 15 years, interviewed at 20 years)

*When the head-teacher found out that I was pregnant, they had to expel me because I was kind of like a bad image to other students in school. So, they made me a scapegoat for other students to see.*

Tanwa (pregnant at 15 years, interviewed at 30 years)

Seale’s (1998) study on social death suggests that social actors (e.g. community members) can engage in a ‘social burial’ (p.170); by actively reinforcing exclusion and marginalization among those perceived as inferior. As highlighted in the quotes above, the actions of employers and educational authorities intensified the experience of exclusion among young unmarried women through acts of discrimination. This shows how marginalisation can have multidimensional effects on the lives of pregnant unmarried young women.

5.5.2 Forced motherhood

An internalisation of the negative perceptions of pre-marital pregnancy and motherhood and an understanding of how this might impact their lives were evident in many narratives. In this study, participants conveyed negative feelings about motherhood and expressed regrets over lost life opportunities, in some cases many years after becoming mothers.

*The mistake I made was to give birth young because now I am like a slave. This child ruined all my plans... What I think is that when you give birth young, you can never be okay again. I have thought about it before that can I still do well with my plans in life now and I really don’t think so.*
This example illustrates how forced motherhood can diminish young women’s future aspirations and cause them to lose their self-worth, in this case by Tutu saying ‘you can never be okay again.’ Participants often described their motherhood experiences in terms of loss; it represented a burden, a loss of autonomy and prior identity, involving demands that they were unprepared to make. Our analysis of the data also identified resentful attitudes towards children, which we interpret as a rejection of their new maternal identity. At the time of the interview, Sade, who had been a mother for fifteen years, still spoke of her child as an impediment to achieving her goals in life:

_During that time, I prayed for the child to die, I was always sad and very depressed because I really wanted to abort the baby. I prayed that the child would die during delivery and be thrown into the bush so that I can have the opportunity to go back to school and face my education... All my mates are now working in the complex [teaching hospital] in Oshogbo and some are doing their youth service, but I have not yet amounted to anything because of her...I gave birth to her in sorrow. She is still a source of sorrow to me_.

By using phrases such as ‘always sad’ and ‘very depressed’ to describe her feelings of being deprived of accessing safe abortion services, the above quotation illustrates how forced motherhood can have a negative consequence on the well-being of young mothers. It also shows how young women connect their powerlessness and current lack of opportunities to forced motherhood.
Sade has acknowledged that she wished – ‘prayed’ – for the child to die, and other participants spoke of abandoning their children in order to ‘start again.’ For example, another study participant said:

When I first gave birth to her, I used to wish I can just leave her somewhere, maybe in a church or in front of someone’s gate [house] so that I can be free and start again. I still think about it now sometimes.

Ola (pregnant at 17 years, interviewed at 20 years)

While this demonstrates a struggle with maternalism at a personal level, this can also be seen as a desire by young women to restore control and ‘normalcy’ into their lives after an experience of disempowerment and loss of reproductive autonomy due to forced pregnancy and motherhood. However, none of the participants was able to do this.

These narratives of resentment towards children were widely evident: several participants spoke of their children as having ‘stolen their youth’ and perceived them to be the reasons why they ‘failed to become somebody in life.’ In some instances, participants also reported transferring aggression to their children because of the negative life experiences that they encountered, which they believed was as a result of becoming pregnant at a young age.

My child has been my obstacle. My child has been my stumbling block…. I have people that can help me to start a trade or business but this child, this child, it is what is stopping me… I wish I did not have her at all. It would have been better for me to abort it… I sometimes speak badly to her, I react badly to her and I tell her that why did she come to me, why did she choose me as her mother

Sayo (pregnant at 15 years, interviewed at 20 years)
Components of abortion stigmatisation include an unwillingness for motherhood (Cockrill & Nack, 2013, p.975). The above excerpts suggest that the unwillingness to become a mother has the potential to affect the wellbeing of young women and their relationship with their children.

6. Discussion

The study findings show how participants unplanned pregnancies prompted justified fears of stigma, and motivated study participants to seek abortion. Although all fourteen young women said they had wanted an abortion, four did not attempt due to perceived socio-cultural constraints; for them, the illegality and the stigma of abortion trumped that of unmarried motherhood. Among the ten that attempted abortion, their pathways were found to be complex and unsafe, mostly due to their limited financial resources. Most young women attempted some form of medical abortion up to three or four times, but their knowledge of correct dosages and regimens was limited, leading to failed abortions. As a result, they carried unwanted pregnancies to term and experienced forced motherhood which had significant negative economic, social and wellbeing implications.

Pregnancy and motherhood are major events that can be particularly life-changing for young unmarried women in Nigeria where pre-marital sex is highly stigmatized (Onyeka et al., 2011). As shown in this study, sexual activities and the timing of reproduction among women are subject to social control. Thus, the desire for abortion among study participants occurred within the contexts of socially constructed norms on pregnancy and motherhood, in which unmarried motherhood was punished by labelling, stereotyping and exclusionary practice. The decision to attempt abortion often stemmed from fear of social stigma, educational disruption, and anxiety about motherhood. However, the legal restriction on abortion in Nigeria limited access to safe abortion services for

20
these young women. The extent to which women are forced into motherhood as shown in this study is an under-represented aspect of reproductive governance within the Nigerian context.

While mothering is believed to have a positive impact on society, early motherhood among unmarried women is stigmatized as it threatens the ideal image of the family (Onyeka et al., 2011). Here, the complexity of stigma is evident as the societal and legal control over women’s reproductive bodies, which propel women towards abortion as a stigma avoidance strategy, also prohibits abortion. The combination of these two competing stigmas provided an enabling environment for clandestine practices and unsafe abortion, as seen in this study.

The decision to resolve a pregnancy through abortion does not lie only with the woman (Akande et al., 2020). Although there are no direct estimates of abortion-related mortality and morbidity in Nigeria, a national survey estimated that 6,000 preventable abortion-related deaths occur annually (Bell et al., 2020). The fears of abortion-related death amongst the participants in the present study that prevented some participants from attempting an abortion were therefore well-founded.

However, it was not only the illegality of abortion and the corresponding lack of abortion services that limited young women’s access to abortion; associated religious and socio-cultural beliefs also had significant influences on young women’s resolution of their pregnancies. These findings parallel studies on abortion stigma which suggest that abortion stigma can influence young women to continue with their unwanted pregnancies and assume a disproportionate burden for childrearing (Chiweshe & Macleod, 2017; Oginni et al., 2018).
Similar to findings conducted in Southern Nigeria which suggest that adolescents often seek abortion to avoid negative social consequences (Envuladu et al., 2017); our findings show that the legal and health implications associated with abortions were not strong enough to dissuade many participants from attempting abortion, in some cases multiple times. A crucial component of young women’s SRH is access to abortion-related services and information, as this goes a long way in determining whether they can successfully achieve abortion (Bell et al., 2020). Our findings on abortion pathways are in keeping with evidence from another Nigerian study showing that in the absence of safe abortion services, young women engage in self-help practices and procurement of medications with abortifacient properties (Oyeniran et al., 2019). There is evidence to suggest that with increased access to misoprostol in countries where abortion is illegal, women are able to obtain safe illegal abortions and successfully achieve abortion (Hyman et al., 2013). This can reduce the harm of self-termination and improve women’s reproductive health in Nigeria.

Although safe illegal abortions are becoming available (Hyman et al., 2013); in instances where study participants tried to obtain safer abortion services, the financial cost of these services made procuring an abortion difficult. As all participants were young, estranged from their families and enduring adverse economic situations, their narratives show how withholding access to abortion can widen social inequities (in age and income) and increase vulnerability to failed abortions and forced motherhood. Due to these financial constraints and limited knowledge on how to terminate a pregnancy, all participants who attempted an abortion experienced failed termination of pregnancy.
As most young women in this study experienced failed abortions, their pregnancies served as visible markers for stigma. When describing their experiences of stigma, participants described how being pregnant restricted their autonomy and predisposed them to discrimination. Link and Phelan (2001) state that societal discrimination can create barriers for stereotyped individuals and limit their access to resources and opportunities. For the young women in this study, the discrimination experienced had significant impacts on their education as many study participants reported a lack of support in returning to school or getting into new schools. Thus, for most of them, expulsions marked the end of their academic pursuits. As all study participants were already experiencing economic difficulties prior to their pregnancies, the added discrimination which limited their access to employment opportunities also exacerbated this hardship. This reveals the depth of marginalization that can occur in young women’s lives due to stigma. Participants’ experiences thus echo existing studies conducted in the United Kingdom, on how early pregnancies can create social exclusion for young women and lead to social death (Ellis-Sloan, 2014; Whitehead, 2001).

Early motherhood can be distressing when it is unwanted. Similar to studies conducted in the United States, which show that forced motherhood is associated with poor mental health and socio-economic outcomes for mothers (Barber et al., 1999; Biggs et al., 2017; Foster et al., 2018), participants’ experiences of motherhood incorporated poor wellbeing outcomes, a rejection of maternalism and resentment towards their children. These narratives challenge the gendered belief system that motherhood is desirable by women and suggests that there is no singular experience of mothering. Thus, highlighting the complex issues that can emerge in women’s lives due to being forced into motherhood.
For many study participants, the experience of stigma and discrimination continued from pregnancy into motherhood. In addition to being stigmatized during their pregnancies, participants experienced single parenthood, a loss of social identity within their communities, loss of peer relationships, and difficulty in returning to school or gaining employment to support themselves and their children. Without welfare and social support, their opportunities for educational and economic advancement were severely limited. This experience of loss, social isolation, social rejection, and social disadvantage, imposed by the society on study participants, represents a form of social death, highlighting the impact that forced motherhood can have on the lives of unmarried young women.

Link and Phelan (2001) suggest that the undesirable attributes attached to an identity determine how individuals would react to it. As pre-marital pregnancy carries a visibly discrediting attribute in Nigeria, this paper has shown how stigmatization can bring about a sense of loss for the ‘past self’, which has been lost due to inability to access abortion; and the ‘present self’, which cannot be attained due to forced motherhood. This research thus highlights failed abortion and forced motherhood among unmarried young women as a crucial issue in Nigeria that requires due attention.

We acknowledge that there are some limitations to this study. The data were generated by a small qualitative sample. We also acknowledge the absence of male perspectives in pregnancy and abortion decision-making. Nevertheless, combined with the other literature drawn upon, we believe that we have identified beliefs, processes, and experiences that some women dealing with
an unwelcome pregnancy (in countries where safe abortion is not readily available) may experience.

6. Conclusion

A less considered aspect of the abortion ban is the consequences of failed abortion and forced motherhood. This study has shown how restricted access to abortion services can enforce motherhood and impact women’s social and mental wellbeing. The results also further reinforce the importance of taking a holistic approach to addressing the SRH of young women by focusing not only on physical health but also on ensuring wellbeing. It also highlights the importance of improving women’s reproductive autonomy in decision-making as this may reduce the rejection of maternalism. Some policy implications arise from this paper.

First, our results suggest change is needed in countries, like Nigeria, that combine restrictive abortion laws with cultural values that stigmatise abortion and unmarried motherhood. This is drawing on our findings which show that it is not only the unavailability of abortion services that limits young mothers’ access to abortion, as some women were also constrained by abortion-related stigma. As Nigeria is a signatory of the Maputo Protocol which guarantees sexual and reproductive health rights for women, this can be drawn upon to advocate for policy change.

It is also important to consider how the criminalisation of abortion might affect the social and mental well-being of unmarried young mothers and their children. In our findings, failed abortions predisposed young women to discrimination and being forced into motherhood resulted in several women rejecting maternalism. Study participants described their children as obstacles, stopping
them in business or attending school. Although no study documents employment discrimination among unmarried young women with children, previous research in Nigeria notes discriminatory educational practices due to early pregnancy and motherhood (Onyeka et al., 2011). Policy interventions are thus needed to mitigate the potential negative consequences of early childbearing.

There is also a need to support young mothers into work. This is not just in the form of training and employment opportunities, but a provision that supports women in the combination of their childcare and economic roles, as this is not well acknowledged in policy discourses in sub-Saharan Africa.

Acknowledgements:
The authors extend their appreciation to the young women who participated in this study.

Declaration of Interest: None

Funding: This work was supported by The Open University’s Faculty of Wellbeing, Education and Language Studies.
References


