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Ambiguous Ambitions

On pathways, projects, and pregnancy interruptions in Cameroon

Erica van der Sijpt

AMBIGUOUS AMBITIONS

On pathways, projects, and pregnancy interruptions in Cameroon

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AMBIGUOUS AMBITIONS

ON PATHWAYS, PROJECTS, AND PREGNANCY INTERRUPTIONS IN CAMEROON

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aan de Universiteit van Amsterdam
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'Ī gīt abong ia di līk bi'. This Gbigbil proverb, which literally means 'the elbow never disregards the back', denotes a sense of connection, support, and reciprocity that is so important in the Eastern Cameroonian village where I did research. Used as it is to remind people of their indebtedness to the pillars and social networks supporting their personal projects, it is also applicable to me now that I have finished the long and collaborative project that my Ph.D. trajectory has been. Indeed, many people have served as that back that kept my elbow writing, and without them this thesis would never have been accomplished. In order not to disregard them but rather, in line with the proverb, give them the honour that they deserve, I would like to explicitly acknowledge the indispensable contribution and support of several groups of people.

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PROLOGUE

Sometime towards the end of December 2004, on a hot and lazy Sunday, I was informed that a young woman at the other side of Asung[1] had miscarried. I had already spent three months in this Eastern Cameroonian village, but had never witnessed an immediate instance of loss; so far, my anthropological explorations had consisted of interviews and hypothetical chats about pregnancy interruptions with the local Gbigbil people. Now, on this sun-drenched day, the news of Celestine's miscarriage vividly spread through the village and was eagerly told to me as well. I was excited, but at the same time anxious about approaching an unknown woman who had just lost her baby. But my anthropological courage somehow surmounted my own culturally shaped uneasiness to confront bereavement, and I hesitantly approached the compound people had pointed me to. I found a group of women, sheltering from the sun in a thatch-roofed open hut – some combing and braiding each other's hair, others lying down on the wooden benches, the oldest one preparing a reddish sauce on the smoking fire. The scene was far from exceptional.

After greeting all those present by offering my wrist to their outstretched hands and formally exchanging information on our health, sleep, and well-being of family members, I asked if the woman who had miscarried was here. I was surprised to see one of the young women sitting opposite me indicate that it was she. Celestine was a young woman with a round, glimmering face and deep-set, sparkling eyes. She seemed friendly and willing to talk, and immediately invited me to sit with her in her mother's kitchen, 'because it is so hot out here and the smoke of the fire might irritate your eyes'. Maybe she felt my discomfort in speaking of her miscarriage in public. Perhaps it reflected her own uneasiness with the situation.

Alone with me in the kitchen, Celestine offered me a leaf-wrapped cassava stick. As she nibbled on her own stick, she began to talk about her experience. Sadly, but with a trace of pride in her story, she told me how she had suffered the pain all alone, how she had secluded herself behind the huts, and how she had panicked when she suddenly saw a little arm sticking out of her vagina. With the help of a neighbouring *mama*, the five month old foetus had finally been expelled and quickly buried.[2] The decomposed corpse of the little baby boy had been a horrible sight. 'Maybe it was the heavy work I have been doing in the fields, and I

also suffer from jaundice in my belly', she replied when I asked her what could have caused this. Though people had told me that Celestine *herself* had attempted to abort this pregnancy, I did not dare to pose further questions. Instead, I gave her a notebook and proposed that she keep a diary. I hoped it would enable her to write down whatever she wanted to share with me, in her own words, in her own time, and at her own pace.

The diary turned out to be a fiasco. Not used to writing in French, and unfamiliar with assumptions regarding privacy and inner feelings as well as the daily routine of diary-keeping, Celestine ended up writing a sort of explanatory report – full of cultural norms and general knowledge, but bereft of personal feelings, reflections, and experiences. Far more insightful were the many lengthy conversations we had while preparing food or going to the fields together in the months after our initial acquaintance. Celestine shared her worries about her boyfriend, who did not seem willing to assume his responsibilities towards her and her family. She repeatedly indicated that she was suffering with him. She even admitted that soon after she detected her missed period, she had attempted to get rid of the pregnancy, but had been warned by a friend that this could kill her. Celestine had finally decided to keep the pregnancy; after all, her previous baby had also died and she wanted her only daughter to have at least one little brother. She constantly insisted that the miscarriage had not been her fault, but was due to the illness in her belly that she was now desperately trying to cure. She showed me the leaves and bark that older women in the village had given her to 'wash her stomach'. When I left the village two months later, Celestine was still under treatment. Having become one of my best friends over this short period, she cried when I hugged her goodbye. With tears in her eyes, she gave me one of her self-made bracelets and said, 'Erica, there are so many things that I still want to tell you. But will you still find me here when you come back? Please take this as a souvenir from me'. It is as if she felt we would never see each other again.

One year later, back in the Netherlands, I received a phone call from an informant announcing that my friend Celestine had died. The illness in her belly had persisted and had made her thin and weak. She had gone to her grandmother to seek another treatment, but now the news had arrived in the village that she had passed away. I was sad and confused. But when I called my informant one month later and inquired about Celestine's burial, she told me that the news of Celestine's death had been a false rumour; my friend was now back in the village, but was still ill and suffering. The disapproval that I detected in her voice suggested that the stories of Celestine's attempts to induce abortion were still circulating, and had made outsiders critical of her suffering.

Expecting to meet my friend when I returned for another round of fieldwork in 2007, I was disappointed to hear that Celestine had died. Her story was recounted many times by women who emphasized the risk of dying after induced abortion. Celestine's elder sister Sophie, who became one of my closest informants at this time, nevertheless denied all accusations of abortion and told me her beloved sister had fallen victim to witchcraft. She related how a family dispute had induced witches to fill Celestine's womb with mystical water, how the two sisters had secretly visited several indigenous healers together, and how all the *marabouts* had told Celestine that it was already too late and that she would eventually die.[3] In a bitter and sad tone, Sophie declared, 'If she had attempted to abort this pregnancy, the child would have come out immediately, not after five months, totally black and rotten. This was obviously the work of witches and not of Celestine!'

Celestine was never able to tell me her whole story. But the rumours swirling around her revealed to me the complex interactions between women's reproductive fears and desires, between norms and practices, between suffering and agency, and between different discourses and decisions that surround reproductive interruption. They gave me an idea of what must have been at stake for Celestine, and for Gbigbil women more generally. This thesis is the result of an anthropological exploration of these complexities; it aims to shed light on the experiences, ambitions, and decisions that surround reproductive interruptions in the East of Cameroon.

I dedicate this dissertation to Celestine and to all women who suffer, or even die, from reproductive interruptions in settings where their experiences are frowned upon. Although some of their stories remain untold – hidden in secrecy and ambiguity, or even tragically silenced by death – this thesis explores the stories of my informants and friends in Cameroon who *were* able and willing to express their ideas about motherhood, interrupted fertility, and what was reproductively at stake for them. Stories of wanted and wasted pregnancies. Stories of social tensions and solitary tactics.[4] Stories of reproductive pathways and projects. Stories of ambiguous antenatal ambitions.

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INTRODUCTION

Initially, Celestine's pregnancy interruption seemed quite exceptional. Never before had I heard so many people comment so openly on a case of interrupted fertility. Yet this one was publicly discussed, interpreted, and judged by Gbigbil men and women alike in this Eastern Cameroonian village. I wondered whether it was the late gestational phase when Celestine had lost her foetus or the horrible sight of the decomposed baby boy that had shocked people; whether her previous loss of a baby had made the event circumspect and subject to gossip; or whether her initial admission of wishing to abort had led to this upheaval. Maybe all of these had violated expectations to such an extent that villagers felt they could transgress the norm of maintaining silence over reproductive interruption. Cases of interrupted fertility, I was assured, normally remained hidden and unspoken of. Especially during pregnancy and in the company of pregnant women, people were not to talk about such cases – not even when it concerned distant others. To prevent further misfortune, women who had just lost their pregnancies were strongly advised not to think or publicly talk about it.

Yet silence on any given issue does not render it meaningless; on the contrary, silence often signals that something crucial is at stake. As Barth (1975) wrote decades ago, secrecy endows the hidden subject with enhanced emotion and value, where knowing more can be dangerous or painful – something that Celestine's story attests to.[1] The gossip and multiple recountings that spread around the village once her experience became public demonstrates that interrupted fertility violates norms, disrupts expectations, and makes explicit – for women, for their environments, as well as for the researcher – secret stakes and contestations around reproduction. If these instances and stories should normally remain covered by silence and norms, over time I discovered they were multiple in the field.

Pregnancy loss is a common phenomenon worldwide. Though rates of interruption vary by locale, it is estimated that at least fifteen percent of all clinically recognized pregnancies end in miscarriage, and that approximately one in fifty foetuses are stillborn (Rai & Regan, 2006; Regan & Rai, 2000; World Health Organization, 2007b).[2] There is widespread agreement that the chances of miscarriage increase with age and that experiencing one interruption of pregnancy increases the risk of subsequent losses (Brigham, Conlon, & Farquharson, 1999; Clifford, Rai, & Regan, 1997). Furthermore, women in all times and places have, for any number of reasons, felt the need to terminate their pregnancies. Over a life course that may include multiple pregnancies, women are

very likely to experience some form of interruption at least once. Celestine and many of her neighbours, friends, and family members in Asung could readily identify with this; sixty percent of the 240 women who had ever been pregnant and who participated in my 2007 demographic survey reported at least one 'wasted pregnancy' in their lives.[3]

The current introduction reviews how reproductive interruptions – and the surrounding silence or stories – have been approached within anthropological debates on fertility and reproduction. It traces the underlying assumptions of past and current ethnographies and critically examines how three simplifying dichotomies have informed many of these studies. Against this background, I outline the central approach of this dissertation, which aims to make sense of the complex experiences and ambiguous ambitions of Celestine and many other Gbigbil women in the East Province of Cameroon.

Reconsidering reproduction

My discoveries in the field somehow seemed to run parallel to the historical development of anthropological insights on human reproduction. Just as my initial encounter with the silence and normative accounts that blanketed reproductive interruption grew into an exploration of complex, contested, and multi-layered events and stories, anthropology has witnessed a comparable 'opening up' of the field of human reproduction. The centrality of sexuality and fertility in the daily lives of people notwithstanding, early anthropological studies paid scant attention to reproductive matters. If analysed at all, reproduction was conceived of in abstract terms with an emphasis on its outcomes; interest focused on the reproduction of economic relations, kinship groups, relations of political dominance, or society itself (Hann, 2008). Human reproduction – the conceiving and bearing of children – remained out of sight or only marginally and normatively described, perhaps because of its perceived biological universality or its association with the female realm.[4]

It was only with the influence of second wave feminism in the 1970s, as well as the appearance of Brigitte Jordan's *Birth in Four Cultures: A Cross-cultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States* (1978), that anthropologists became interested in the minutiae of childbirth and its social and cultural dimensions. It resulted in the emergence of a new field – 'the anthropology of birth' – in the 1980s, focusing on the cultural organization and variability of childbirth and postpartum practices around the world (Kay, 1982; Laderman, 1987; MacCormack, 1982; Sargent, 1989).

While the resulting ethnographic descriptions of birthing cultures addressed reproductive interruptions, they did so only indirectly. Detailed investigations of existing taboos, prohibitions, and precautions taken during pregnancy to ensure safe and successful deliveries shed light on local perceptions of pre- and perinatal dangers and risks. There was also growing interest in the local varieties of fertility regulation and the diversity of motivations for birth control.[5] Topics ranging from breastfeeding and child

spacing methods to local abortifacients, contraceptives, and sterilization techniques were elaborately documented and compared cross-culturally (Newman, 1985). Although these studies filled gaps in our knowledge about the practices and meanings of reproduction – rather than merely its outcomes – descriptions remained mostly normative. Most ethnographies created a coherent account of a birthing *system* in which beliefs and practices were considered to be reflections of underlying cultural patterns – with the holistic concept of 'culture' disregarding variations, contestations, or multi-level power differences (Van Hollen, 1994).

Normative accounts of fertility desires and practices also exist for the East of Cameroon, where Celestine and I met. Descriptions abound on the value of fertility within local patrilineal kinship systems, the symbolic imagery surrounding reproduction, and the rituals and traditions that exist to ensure a large number of offspring (Copet-Rougier, 1985; de Thé, 1970; Héritier, 1984; Laburthe-Tolra, 1985; Vincent, 1976). Especially in the East Province, men and women alike – for both economic and ideological reasons – are described as being in a permanent quest for children (Wakam, 1994). The considerable sexual liberty granted to girls and women in the East of Cameroon is further seen as leading to abundant childbearing in and out of wedlock, and has been contrasted with, for example, the Bamiléké people in the West of Cameroon who are seen as much more calculating regarding both economic and reproductive matters (Feldman-Savelsberg, 1999; Yana, 1994, 1995).

This picture of uniform fertility desires has been reinforced by a whole body of literature focusing on *infertility* in the region. From the late nineteenth century onwards, many studies have investigated the reasons for, and the consequences of, the low birth rates and high levels of childlessness that seemed to plague the East of Cameroon – as well as surrounding regions in the so-called 'infertility belt' of Central Africa.[6] Explanations were sought in local sexual practices, endemic and venereal infectious diseases, hygiene standards, and dietary habits (Cates, Farley, & Rowe, 1985; David & Voas, 1981; Ericksen & Brunette, 1996; Frank, 1983; Larsen, 1995; Nasah, 1978; Retel-Laurentin, 1974; Romaniuk, 1961, 1967, 1968). The consequences for infertile and sub-fertile women in the region were depicted as dire: given the ideological value placed on fertility, they would suffer physical vulnerability, material deprivation, and social stigma.[7] Taken together, these studies have presented a rather homogeneous picture of Cameroonian women and their intentions regarding fertility. Controversial stories like Celestine's do not appear in these accounts. What they would mention regarding a case like hers is the cultural ideal to maintain silence around reproductive interruption or some locally appropriate means to prevent or heal her misfortune in this uniformly pronatalist region – exactly what was told to me at the beginning of my fieldwork.

My subsequent surprise in encountering numerous incidents of reproductive interruption – enshrouded in stories that only seemed to increase in complexity as my insight into the subtleties of local interpersonal relations developed – could then be

considered analogous to the paradigmatic shift in anthropological theory that took place in the 1990s. Influenced by Foucault, feminism, and an emerging global reproductive health discourse that highlighted reproductive rights, choice, and decision-making, anthropologists in the 1990s began paying greater attention to reproductive discourses, politics, and contestations.[8] Van Hollen describes a historical transformation in anthropological theories of childbirth 'from function to authority':

> Whereas earlier anthropological approaches to reproduction tended to focus on how reproductive practices and beliefs *reflected* social and cultural systems, scholars now argue that anthropology can benefit from viewing reproduction itself as a key site for understanding the ways in which people *re*conceptualize and *re*organize the world in which they live (Van Hollen, 2003, p. 5, emphasis in original).

A whole body of literature has since 'situated' the politics of reproduction, focusing on women's reproductive agency within the conflicting forces and (global) power stratifications of daily life (Ginsburg & Rapp, 1995; Greenhalgh, 1995). In contrast to former normative accounts of fertility, the anthropological gaze now turned towards the marginalized – to people who do *not* attain normative standards – and to counter-hegemonic practices and beliefs in Western and non-Western settings alike. The subject matter also became much more diverse, with ethnographies addressing the micro- and macro-politics of infertility and assisted reproductive technologies (ARTs), contraception and abortion, adoption and cultural ideals of family and parenthood, population policies and social movements, medical constructions and authoritative knowledge, and their relationships with kinship, gender, marriage, and religion (G. Becker, 1994; Ginsburg & Rapp, 1991, 1995; Greenhalgh, 1995; Inhorn & Birenbaum-Carmeli, 2008; Levine, 2008).[9]

Another result of the growing attention to previously marginalized voices and topics was a new focus on involuntary reproductive interruptions. Reacting against medical, demographic, and psychoanalytic treatments of miscarriage and stillbirth, medical anthropologists turned to subjective experiences of loss in different cultural settings (Reinharz, 1988). Rosanne Cecil's edited volume *The Anthropology of Pregnancy Loss* (1996) was a promising start. Cecil argued that pregnancy loss touches upon questions of life, death, humanity, and personhood. As the meanings of these matters vary both over time and across cultures, she called for further comparative research on reproductive mishaps. A number of ethnographers answered this call by investigating the cultural constructions, meanings, and politics around pregnancy interruptions in different parts of the world (see, for instance, the work of Erviti et al. (2004) in Mexico, Jeffery & Jeffery (1996) in India, Njikam Savage (1996) in Cameroon, Layne (2003) and Letherby (1993) in the United States, Littlewood (1999) in the United Kingdom, Rice (2000) among Hmong women in Australia, Sobo (1996) in Jamaica, and Wembah-Rashid in Tanzania (1996)). This attention to reproductive loss uncovered many untouched themes and unheard voices, providing 'a powerful lens (…) for illuminating many other important dimensions of contemporary culture' (Layne, 2003, p. 26). Likewise, once I dug beneath

the silence and normative accounts around reproductive interruptions in my field, there appeared many – often contradictory – voices to be listened to.

Although this dissertation builds upon this recent work on the contexts and politics of reproduction, my findings depart from the extant literature in significant ways. By listening to women and considering their specific norms, discourses, experiences, decisions, and ambitions, the current study suggests that certain dichotomies that dominate the existing literature do not hold for my informants in Cameroon, and probably for many women elsewhere. The following sections discuss three dichotomies that have informed much of the work on pregnancy interruptions – by anthropologists and non-anthropologists alike – but which were questioned or contradicted by the stories of my Cameroonian informants. I will then propose an approach to study reproductive interruptions that eschews these simplifying dichotomies and allows making sense of both the ambiguous particularities and the wider patterns that underlie reproductive experiences.

Miscarriage versus stillbirth

Thinking and theorizing about pregnancy, childbirth, and reproductive interruptions often employ linear time-frames. Dominant biomedical notions trace the development of a fertilized ovum into an embryo, and then into a foetus that is believed to be viable at a specific gestational age. Pregnancies are thus conceptualized as processes evolving over time, expressible in days, weeks, months, and trimesters.[10] This mechanical, time-based notion of the creation and viability of the conceptus dominates biomedical definitions of different forms of pregnancy interruption as well. A miscarriage entails the expulsion of an embryo or developing foetus believed to be unviable, while the loss of a foetus that would have been able to live outside the womb but dies *in utero* or immediately following delivery is a stillbirth. When exactly a foetus is considered viable (and thus when a miscarriage turns into a stillbirth in case of its loss) is understood in terms of gestational time. Most countries have legally established this moment somewhere between 20 and 28 weeks of gestation. Stillbirths during 'late' pregnancy – the exact starting point of which differs between countries – constitute, together with deaths at birth or in the first week afterwards, perinatal deaths. Even if these different definitions lack universally acknowledged demarcations, what holds true for all of them is the persistent effort to distinguish between (more or less mutually exclusive) categories of pregnancy loss on the basis of fixed temporal divisions. Definitions of loss *after* birth are not less time-based: neonatal, infant, and child deaths concern the death of live-born babies within the first twenty-eight days, one year, or five years of life respectively.

Social scientists often take these time-based divisions for granted. Many anthropological studies on reproductive interruptions distinguish between miscarriage, stillbirth, neonatal, and infant death on the basis of such biomedical definitions. Some limit their focus to one of these categories to provide an in-depth study of loss at a

specific gestational phase (Bansen & Stevens, 1992; Gerber-Epstein, Leichtentritt, & Benyamini, 2009; Letherby, 1993; Rice, 2000). Other studies, acknowledging that the meanings and (social or emotional) effects of early and late pregnancy interruptions might not be as different as the separate classifications suggest, consider them together (Cecil, 1996; Haws et al., 2010; Jones, 2001; Layne, 2003; Lovell, 1983). For example, Njikam Savage (1996), who writes about pregnancy loss in West Cameroon, shows how all forms of interrupted fertility are surrounded by similar aetiological notions, risk prevention strategies, and mourning conventions. This and other studies show the irrelevance of artificial distinctions between comparable reproductive events. However, they discard these separate classifications on the basis of their *comparability* in content or consequence, not because they question the underlying *rationale* behind the distinctions. Indeed, the rhetoric of the comparability of 'early' and 'late' pregnancy losses maintains the separate terms and the inherent conception of a linear gestational process that can be differentiated into successive temporal phases.

In her groundbreaking *Contingent Lives: Fertility, Time, and Aging in West Africa,* Caroline Bledsoe (2002) argues against this chronological common sense. Her work, in emphasizing the contingency and indeterminacy of vital events, echoes the recent body of literature critical of the fixed life-cycle model consisting of coherent successive life stages (Caroline Bledsoe, Lerner, & Guyer, 2000; Featherstone & Hepworth, 1991; Johnson-Hanks, 2002b; Lock, 1993b). Bledsoe argues that the framing of time as natural – the so-called 'bodily clock' – has not only been applied to ageing, but to reproductive capacity as well; both demography and anthropology take for granted a relationship between nature, time, and reproductive potential that considers 'the female capacity to reproduce as a chronologically based bodily potential' (2002, p. 55). By deconstructing the idea that linear time is the essence of fertility, she also questions the biomedical time-based distinction between miscarriages and stillbirths. She points out that in other cultural contexts, different forms of pregnancy loss can be distinguished on the basis of other criteria. Her research in the Gambia shows how local interpretations of pregnancy interruption are contingent on the 'physical toll' a woman's reproductive trajectory has already taken. Consequently, experiences of loss are ordered on the basis of notions of physical strength, damage, and rest – rather than time.

That the distinctions between miscarriage and stillbirth, and between stillbirth and infant death, might also be blurred in Cameroon was already suggested by Ardener (1962) when he found that the Bakweri people in West Cameroon distinguish between births that are considered as 'abortive' failures and those that produce, at least temporarily, a breathing infant. In the East Province of the country, however, even this distinction does not always seem to hold. My survey questions – which inquired about 'number of wasted pregnancies' (*grossesses gâtées*) and then 'number of infant and child deaths' – more than once created confusion as women already included babies that had died within the first few months of life under the first heading. Indeed, women would often use the term

'*fausse-couche*' (miscarriage) to denote events ranging from the reappearance of a late period to the death of a newborn baby (see Chapter 3). Happenings like these raise the question of how East Cameroonian women locally define and demarcate various instances of interrupted fertility, and if and how these relate to time-based models – especially since it has been argued that the appropriate timing of reproduction is a major preoccupation of women in the region (Johnson-Hanks, 2002a, 2002c, 2006).

In this dissertation, 'reproductive interruptions' refer to all possible forms of loss that women might encounter and distinguish – not only miscarriages, stillbirths, perinatal and neonatal deaths, but also fertility regulation practices and induced abortions.[11] I do not categorize events according to externally imposed notions of gestational time; instead, I try to integrate an amalgam of reproductive happenings, experiences, and meanings that all touch on women's interrupted fertility. I prefer to speak of 'interruptions' rather than 'loss' or 'disruptions' as the latter carry mainly negative connotations and presuppose abnormality or eventfulness (Grotevant, 2007, p. 123). Loss, like disruption, is always considered eventful in the sense that it occurs when familiar forms and patterns of life are disrupted in ways that threaten continuity of meaning (Marris, 1974). However, as Bledsoe & Scherrer (2007, p. 48) and Jenkins & Inhorn (2003, p. 1832) point out, this sense of disruption depends on people's understanding of what is natural, normal, or expected – conceptions that vary over time and situations. Reproductive interruptions may at certain moments or in certain situations be considered more or less a disruption, more or less a loss, more or less a pathology[12], and more or less an *event*. Not all cases of interruption are as disruptive as Celestine's; others are less unexpected, less meaningful, more part of daily routine or insecurity, and more easily downplayed as a *non-event*.

This study examines both events and non-events; it explores the conditions for their conceptualization as such, as well as their dynamic interrelationships. Reproductive loss is thus reconceptualized – transformed from a clearly demarcated and fragmented biological event into a socially constructed and contingent process. It will furthermore be given local meanings – meanings that are acknowledged to change over time, vary in degree, and be situationally dependent. This approach does not only transcend the dichotomy between miscarriages and stillbirths, but it also leaves aside the question of whether or not the interruption was induced – a second dichotomy that prevails in existing studies and reproductive health discourses, often with important moral implications.

Unintended versus intended interruptions

As recounted above, a paradigmatic shift within the social sciences in the early 1990s made anthropologists more aware of and interested in the macro- and micro-politics of reproduction. Reproductive interruptions (re)appeared on the research agenda in two ways. On the one hand, anthropologists tried to give voice to women who unwillingly fail

to attain reproductive norms and goals, such as those who experience infertility or spontaneous fertility interruptions. These studies aimed to break the silence, taboos, and stigma surrounding reproductive mishaps. On the other hand, a huge body of work focused on the rights, decision-making processes, social movements, and other controversies surrounding induced abortion – reproductive interruptions that were intentionally enacted. Split by the question of 'intentionality', these two literatures addressed, it seemed, two different reproductive domains. This resulted in numerous in-depth examinations of *either* unintended *or* intended reproductive interruptions in different socio-cultural contexts – with studies on induced abortion (see, for instance, Calvès, 2002, 2004; Guttmacher Institute, 2003; Koster, 2003; Renne, 1996, 2006; S. Schuster, 2005; Sylvie Schuster, 2010; Svanemyr & Sundby, 2007) far outnumbering the few publications that focused on spontaneous pregnancy interruptions (see, for instance, Bansen & Stevens, 1992; Caroline Bledsoe, Banja, & Hill, 1998; Cecil, 1996; Feldman-Savelsberg, Ndonko, & Yang, 2006; Jeffery & Jeffery, 1996; Layne, 1997, 2003, 2006; Letherby, 1993; Littlewood, 1999). Studies that examined the interrelationships between the two were few and far between (see for exceptions Chapman, 2003; Koster, 2010; Renne, 2003).

This dichotomy around intentionality suffuses international reproductive health debates as well.[13] Since the 1994 International Conference on Population and Development (ICPD), where previous demographic methodologies and attempts at population management became heavily criticized, two intertwined discourses emerged that shed new light on reproduction in Africa and elsewhere. First, the core concepts of sexual and reproductive health were developed and situated in a framework of rights, liberty, autonomy, and choice. Reproductive health was defined to encompass 'the capability to reproduce and the freedom to decide if, when and how often to do so' (*Program of Action,* paragraph 7.2).[14] Second, attention focused on the improvement of maternal and child health and the reduction of maternal and child mortality. These goals were adopted by international programs such as the 'Safe Motherhood Initiative' (1987) and the 'Making Pregnancy Safer Initiative' (2000), as well as by the Millennium Development Goals agreed to by 189 countries in 2000. Both global agendas allowed for a more diverse and realistic view of people's reproductive experiences; next to high fertility rates, impediments such as infertility and pregnancy interruptions now entered the discussion.

The international acknowledgment of reproductive interruptions led to the promotion of post-abortion care (PAC) as a public health strategy from 1993 onwards.[15] In principle, PAC was meant to cover *all* forms of pregnancy interruption, with emergency treatment for complications resulting from both spontaneous and unsafely induced abortions. The complications are, after all, similar – irrespective of how the interruptions are provoked. Nevertheless, with the predominant focus on (the right to) safe induced abortions and/or the treatment of complications arising from 'unsafe abortions',[16] most

of the attention has been directed towards *induced* interruptions. The PAC model explicitly mentions *spontaneous* pregnancy interruptions only in reference to emergency treatment – a focus on physical complications and management procedures that *medicalizes* women's experiences of spontaneous reproductive mishaps. The more elaborate psychosocial elements of care – community participation, counselling, family planning education, and guidance of subsequent reproductive decision-making – tellingly centre on *induced* interruptions (Corbett & Turner, 2003; Curtis, 2007).[17]

Despite claims to treat pregnancy interruptions as a whole, the international health establishment has thus problematized induced abortions much more than spontaneous ones. The bias towards (unsafely) induced interruptions can be traced to several assumptions. First, induced abortions are more frequently life-threatening than spontaneous miscarriages and thus considered more pressing in reducing maternal mortality. Second, spontaneous and induced abortions are associated with so-called 'wanted' and 'unwanted' pregnancies respectively – the latter being considered highly problematic in a discursive context that emphasizes reproductive *choice* and *rights*. Due to these distinctions, personal experiences of interrupted fertility – *if* mentioned in international discussions – become represented through 'hypothetical women' undergoing *either* induced *or* spontaneous abortions – which are presented as two different typical 'cases' (see also Allen, 2002).

Although anthropologists may be only marginally influenced by such public debates, the discipline tends to reproduce the dichotomy of intended and unintended reproductive interruptions.[18] This thesis tries to counter this tendency. I do not deny that induced abortions and spontaneous pregnancy interruptions can bring about very distinct physical and emotional experiences. Indeed, I think that the bias towards induced abortions and contraception in the post-abortion care model and international discussions *does* tend to ignore the potentially different personal experiences and reproductive wishes of women who spontaneously lose their pregnancies. At the same time, I argue that rigid distinctions between predefined categories of 'wanted' and 'unwanted' pregnancies or subsequent 'unintended' and 'intended' interruptions may not reflect women's reproductive experiences, which are often contradictory, blurry, and shifting – during their life courses as well as during the gestation of a single pregnancy (Earle, 2004; Earle & Letherby, 2002, 2007; Frost & Condon, 1996; Jones, 2001; Potter, 1975). We only need to remember Celestine's story to appreciate the point: she initially tried to abort her 'unwanted' pregnancy and then lost her foetus a few months later, after she had decided to bear the child. Was Celestine's interruption intended or unintended?

Some studies dealing with the question of intentionality in childlessness, interrupted pregnancies, and infanticide have, however, given ambiguity its due. Several ethnographies have described how aetiologies of infertility in different cultural settings reveal both 'naturalistic' and 'personalistic' causes (Foster & Anderson, 1978), where the

latter can include the behaviour – unintended or intended – of the infertile woman herself (Gerrits, 1997; Leonard, 2002; Nahar, 2007; Richards, 2002). These studies show how infertility is often surrounded by questions of guilt, blame, and intentionality that cannot be unambiguously answered – not by outsiders and not by the women themselves. Letherby (1999), in discussing the ambivalence of fertility intentions among both 'involuntary' and 'voluntary' childless women in the UK, follows Monach's (1993, p. 5) proposal to see childlessness 'as a continuum, on which there are those clearly at either end', with 'a group in the middle whose position might change over time'. Letherby adds that not only fertility desires and intentions, but also the significance of non-motherhood, changes over a woman's life. Reasons, meanings, and intentions of childlessness – and, by implication, motherhood – are often dynamic and contested.

The blurred boundaries between induced and non-induced pregnancy interruptions have been explored by Renne (2003), who found that although local Hausa terms in Nigeria distinguish between spontaneous and induced abortions, a clear demarcation often becomes untenable in specific situations. This is especially the case when pregnancies are considered 'weak' and in need of abortion; here the intentionality of the interruption becomes difficult to assess. The opposite condition, where pregnancies cease to develop and are 'too strong' to abort – a phenomenon referred to as 'sleeping pregnancies' (*kwantacce*) and examined in more detail by Kleiner-Bossaller (1993) – reveals a similar ambivalence regarding the question of intentionality. *Kwantacce* can be brought about unintentionally when a woman unsuccessfully tries to abort her pregnancy, which then goes 'to sleep' for several years afterwards; it can be consciously pursued by using herbal medicines in case a woman wants to delay her pregnancy; or it can be intentionally faked by a woman who wants to hide her infertility or postpone entrance into 'old' womanhood. In the end, the condition may prove fatal to both women and their foetuses – losses that cannot be unambiguously called 'induced' or 'non-induced'.

Nancy Scheper-Hughes (1992) was one of the first medical anthropologists to question the precise dividing line between intended and unintended interruptions *after* birth. In her groundbreaking *Death Without Weeping: The Violence of Everyday Life in Brazil*, she shows how poverty-induced scarcity in a Brazilian shantytown influences maternal emotions and behaviour. In a context where child deaths are commonplace, she demonstrates how mothers show delayed attachment to infants and discriminate between those who seem strong enough and willing to engage in 'the struggle for life' and the weaker ones who are subjected to 'mortal neglect'. Not only the lives of these doomed children, but also their deaths are met with indifference; women do not cry at their decease but resign themselves to the belief that some babies are 'angel babies' who just want to return to heaven. Although her claim of 'maternal indifference' has provoked contestation and debate (Einarsdóttir, 2000; Guy, 1993; Hrdy, 1999; Linger, 1993; Margolis, 1993), Scheper-Hughes' research has opened the way for a new theoretical

'middle ground' (1992, p. 356) – not only between the complete presence or absence of motherly love, but also between completely intended or unintended fertility interruptions.

With its aim of understanding what is really at stake for women, this study does not *assume* women's reproductive goals, intentions, and ambitions, but *examines* them. It investigates whether, how, and in what contexts women perceive their pregnancies to be wanted or unwanted, and their fertility interruptions to be spontaneous or induced. Its approach also leaves room for experiences that do *not* fit these separate labels and thus transcend rigid dichotomies; it explores what happens when pregnancies are perceived as both wanted and unwanted at the same time, or when this question of desirability is simply not deemed relevant. Likewise, I describe what happens when reproductive interruptions cannot unequivocally be classified as induced or spontaneous, and how this question of accountability can become an issue of constant contestation and negotiation. This dissertation views as a whole reproductive incidents that used to be studied separately; it does so because they are dynamically related to each other – and are sometimes even indistinguishable – in people's daily lives and narratives. In this way, it overcomes another theoretical dichotomy that seems equally artificial when taking women's complex experiences into account: the one between suffering and agency.

Suffering versus agency

Underlying the distinction between intended and unintended pregnancy interruptions is a more general distinction between actions that are purposefully committed and misfortunes that befall women without their asking. This touches upon questions of autonomy and choice as well as restrictions that are imposed by external influences and that lead to suffering. Feminists – who have spearheaded the critical review of both the social sciences and the international debates surrounding reproductive health (Auerbach & Figert, 1995; Green & Thorogood, 1998) – have emphasized both: they have stressed women's subordination and suffering within exploitative institutions and dominant male-centred discourses, as well as their autonomous capacities, which can be used in their liberation from patriarchy.[19] Despite growing recognition that structural constraints and agency are mutually implicated rather than two distinct versions of reality (Bourdieu, 1977; Giddens, 1986), there is a remarkable association of spontaneous pregnancy interruptions with suffering and of induced abortions with autonomy.

Current studies on spontaneous reproductive interruptions approach the event mainly through a framework of loss and, by implication, suffering. Loss in childbearing is almost invariably linked to loss of women's *power* within a wider structural context. Feminists have been especially eager to show how society's dominant 'truth claims' – internalized and normalized by men and women alike – are pervaded by a patriarchal discourse that restricts women's social status to their capacity to reproduce and nurture (Bourdieu, 2001; Chodorow, 1978; Ortner, 1996; Tronto, 1993). Women who experience

problems attaining motherhood thus suffer multiple hardships. Not only do they have to endure *physical* pain; dominant social institutions and patriarchal norms also generate *psychological* distress as well as *social* stigmatization and powerlessness. The subordination of women who fail to produce offspring – and reproduce the social order – due to infertility or sub-fertility is multi-faceted: not only do they feel inferior to men, but also to women who *do* meet the imposed male standards, and derive social power from it. Tellingly, Leonard (2002, p. 104) speaks of these women as a *third gender*, not fitting existing structures and social positions.

This association of reproductive loss with women's suffering is further reflected in the many studies that deal with bereavement after miscarriage and stillbirth (Bansen & Stevens, 1992; Brier, 1999; Conway & Russell, 2000; Cuisinier, Graauw, Kuijpers, Hoogduin, & Minnen, 1992; Frost & Condon, 1996; Jones, 2001; Letherby, 1993; Puddifoot & Johnson, 1997).[20] Whether or not early and late pregnancy interruptions are deemed comparable, all studies show that reproductive mishaps can be followed by intense feelings of grief and sadness – for both men and women. They thereby cast doubt on the possibility of a pregnancy interruption being a 'non-event' (Bourne, 1968), of minor importance in a woman's or couple's daily life. The bereavement that parents feel, however, is critically assessed to have no place in Western societies. Many of these studies therefore focus on the role of religious associations, self-help groups, and biomedical staff in assisting women through this hidden emotional suffering (see Brier, 1999; or Frost & Condon, 1996; Jones, 2001; Layne, 2003, 2006; and for critical reviews of this literature, see C. Lee & Slade, 1996).[21]

Some critical studies have related this *emotional* suffering to another institutionalized 'truth claim' focusing not on the status of the mother but on the status of the foetus. Especially where high-tech antenatal facilities and/or strong religious convictions prevail, pregnancy interruptions can be experienced as the loss of the early *life* of what would have become a baby. Implicitly or explicitly drawing on maternal bonding theories that portray women as emotionally attached to their babies from very early on in their pregnancies (Bowlby, 1980; Klaus & Kennel, 1976), these studies argue that such constructions of foetal life and personhood aggravate distress when the bond is ruptured.[22]

Whether the emphasis is on the loss of motherhood and its status within society, or the loss of foetal life, what emerges is a picture of reproductively failed women as passive sufferers, as victims of fate. The limited power that *is* granted to them is defined in terms of 'coping' – more emotion than problem-oriented in cases of miscarriage and stillbirth.[23] Women can try to ease their physical suffering, come to terms with their loss emotionally, or try to escape from the influence of social norms that heighten their suffering. But since women are 'overcome' by the event and 'over-ruled' by its attendant truth claims, they can do little to reframe their problems which 'have their origins and

consequences in the devastating injuries that social force can inflict on human experience' (Kleinman, Das, & Lock, 1997, p. ix).

In contrast, cases where women rid themselves of 'unwanted' pregnancies have been celebrated by many feminists and others as the ultimate freedom of choice. In this view, abortions are manifestations of women's control over their own bodies and lives, and of their ability to decide *not* to adhere to imposed norms, but to focus on their own well-being and individual life goals instead (Fischer, 2003; Hanigsberg, 1995; Hewson, 2001; E. Jackson, 2000; Thomson, 1971).[24] This celebration of abortion as autonomous choice – as well as the 'empowerment' promoted to enable women to make such decisions – resonates with a larger rational choice discourse within current international health debates, and with a focus on politics and power struggles within the social sciences.

Understanding abortions in terms of autonomy and rational choice leads to at least three misrepresentations of reproductive decision-making. First, the individualist underpinnings of this interpretation tend to ignore the mutual implication of women's reproductive agency with social others and structural factors. The discourse focuses on women as *individual* agents who (have rights to) make rational, free, and informed decisions regarding the number of children they want, or their unwanted pregnancies. It overlooks other social relations – and their power dynamics – often implicated in reproductive decision-making (see for similar critiques Brand, 2001; Ortner, 2006; Watkins, 1993).

Second, it posits that fertility can and should be rationally calculated and controlled – whether in terms of an envisaged 'ideal family size' at the outset of a woman's fertility career or through assessments of the 'desire for another child' at each pregnancy (Bulatao & Fawcett, 1983). This rather economic projection is highly problematic in the field of sexuality and reproduction; sexual activities are often spontaneous, reproductive outcomes unanticipated or uncertain, and reproductive desires contested, multiple, and changing. In the face of an inherently uncertain gestational process, reproductive agency and manipulation are always somehow limited.

Finally, a third shortcoming of the focus on autonomy is its tendency to only consider explicit, crucial moments of decision-making. Agency is at play in many gradations and in many situations over the whole life course – even where no explicit decisions are made, where women seem to comply with dominant structures, or where they dismiss the situation at hand as a 'non-event'. Ortner (2006, p. 145) thus speaks of an agency of 'projects'. Projects are culturally constituted desires and goals infusing life with meaning and purpose. They may be overt and inspire explicit manifestations of power and decision-making, but may equally be covert and less explicitly manifested – inspiring, for instance, seemingly 'passive' endurance or subtle manipulation. In the field of sexuality and reproduction, behaviour is often based on covert projects as much as on

overt ones; focusing solely on explicit manifestations of decision-making leaves out many other ways in which reproductive agency can be practiced.

A rigid distinction between spontaneous and induced interruptions in terms of suffering and agency inevitably leaves out the many subtleties, variations, and mutual implications of different forms of interrupted fertility. Thus the question is not whether one form of interruption can be more or less related to autonomous agency or structural constraints – a question that focuses on the *amount* of control and constraint. Instead, I find it more valuable to think in terms of the *kinds* of agency people display within specific social settings and the *kinds* of obstacles they encounter in directing their sexual and reproductive lives – and how the two relate to each other at different moments in life and in different instances of reproductive interruption (see also Paxson, 2004). Of critical importance here is how people *themselves* enact, talk about, and give meaning to different forms of agency and suffering. Just as I propose the all-encompassing concept of 'interrupted fertility' to transcend the boundaries between miscarriage and stillbirth, and intended and unintended interruptions, I cast a wide net to capture the broad range of fertility behaviour, thereby allowing for space between 'active' and 'passive' concepts of reproductive decision-making (Carter, 1995).

Here I draw on a few anthropological studies that have explored the dialectic between women's passivity and agency in Cameroon – though not explicitly with reference to reproductive interruptions. These studies refine earlier functionalist views that had described Cameroonian women as subordinate to men. Especially with regard to the Centre, South, and East Provinces of the country, descriptions of social structures and kinship systems have stressed the importance of 'wealth in people', where men's power and prestige is based on their ability to mobilize followers through marriage alliances and relations of patronage (Johnson-Hanks, 2006; Vincent, 2001; Yana, 1994). Women in these settings have often been described as objects to be acquired, exchanged, and fertilized by prestige-seeking older men; commanded by their husbands and in-laws, reproduction was out of their control (Yana, 1994). In his edited volume *Femmes du Cameroun: mères pacifiques, femmes rebelles* (1985), Jean-Claude Barbier counter-poses this view of 'the oppressed African woman' with the complexity and diversity of women's multiple social roles. Case studies from many localities in Cameroon indeed show how these roles imply different social functions, political and ritual powers, and possibilities for strategic behaviour, autonomy, individuality, and independence.

In addition, several accounts of female sexual militancy in Cameroon show that reproduction and sexuality are arenas where women *do* manifest different kinds of agency. Ardener (1973) describes women's rebellious use of obscenity in West Cameroon in cases where they feel insulted as a sexual group by collectively exposing their buttocks or genitals in rituals called *titi ikoli, ndong,* and *anlu*. She sees these actions as public demands for respect of women's sexual identities – what she calls their 'femineity'. It is womanhood itself that is considered and enacted as inherently valuable and exclusive – a

point also made by Copet-Rouger (1985) for the Mkako in East Cameroon. These underlying feelings of female pride and revolt can become intense and highly politicized (Nkwi, 1985; Van Allen, 1972). A comparable provocative ritual undertaken by Maka mothers-in-law in the East of Cameroon is interpreted by Geschiere (1985) in terms of the ambivalence and tensions inherent in their position as strangers in their husband's patrilineage. Somewhat less provocatively, but no less assertively, polygynous Mkako women in the same province have been described to actively engage in informal polyandry – a practice which challenges the dominant view of women's sexual subordination (Notermans, 1999). These studies all show how women assert themselves – as mothers, wives, co-wives, sisters, sexual beings, or strangers – within male-dominated settings. Women are thus more than passive bearers of patriarchal norms, though their struggles and tactics must be situated within these ideological surroundings.

Whereas scholars have placed caveats around the image of the powerless, suffering Cameroonian woman, the same has been done for too-autonomous views of reproductive strategies in the country. Recent studies of induced abortions in Cameroon have shown that women's motivations and practices can only be understood when placed within their local social contexts (Calvès, 2002, 2004; Feldman-Savelsberg, Schuster, & Ndonko, 2008; Guttmacher Institute, 2003; Johnson-Hanks, 2002a; Schuster, 2005). Often cited reasons for abortions include economic hardships, marital problems, relational instability, or peer pressure – indicating that reproductive decisions are often far from autonomous or individually taken.

These studies also show how women's reproductive agency is not only related to *structure,* but also to *suffering*. Many accounts relate how unsafe abortion practices are often followed by secondary infertility or death (Koster, 2003; Larsen, 1995; Okonufua, 1994; Renne, 1996, 2006; Schuster, 2005; Svanemyr & Sundby, 2007). My informants in East Cameroon also constantly integrated ideas of suffering and agency, but did so in more inventive and encompassing ways. Indeed, it is the often-heard complaint '*je souffre*' ('I'm suffering', in physical, but also in economic or relational terms) that women like Celestine almost paradoxically invoke when accounting for their reproductive agency – something I will call 'the paradox of powerless portrayals'. By paying attention to such meanings and combinations of 'agency' and 'suffering' at different moments of interrupted fertility in the lives of Cameroonian women, I aim not only to overcome rigid dichotomies, but also to prioritize women's *lived experience* of reproductive interruptions – which Gammeltoft (2006) and Koster (2003) have called for as well. With this aim in mind, I now turn to the central approach of this dissertation.

'Situating' reproductive interruptions

> *…the particulars suggest that others live as we perceive ourselves living – not as automatons programmed according to 'cultural' rules or acting out social roles, but as people going through life wondering what they should do, making mistakes, being opinionated, vacillating, trying to make themselves look good, enduring tragic personal losses, enjoying others, and finding moments of laughter. It is hard for the language of generalization to convey these sorts of experiences and activities* (Abu-Lughod, 1993, p. 27).

As recounted above, discussions about fertility issues have been pervaded by abstract dichotomies that do scant justice to reality. Experiences of interrupted fertility are diverse and complex, interwoven with different domains of social life, and interpreted through different discourses and systems of meaning. To capture the real life ambivalence and ambiguity of reproductive interruptions, I propose framing them as *vital conjunctures* – a concept developed by Johnson-Hanks (2006) in her study of motherhood among the Beti in Southern Cameroon, where she examines how young women who aspire to good education and financial security experience uncertain, ambiguous, and seemingly contradictory desires and hopes in the face of unexpected pregnancy. Building on Bourdieu's practice theory, the concept of vital conjunctures – which Johnson-Hanks defines as 'socially structured zones of possibility that emerge around specific periods of potential transformation in a life or lives' (2006, p. 22) – captures the structures, constraints, and possibilities that Cameroonian women encounter at possible turning points in their lives. First pregnancy and entry into motherhood are good examples of vital conjunctures; they are characterized by extreme uncertainty, potential for the radical transformation of life trajectories or previous pathways, and new orientations to the future. Johnson-Hanks calls the possible future scenarios that people imagine in such 'critical durations of uncertainty and potentiality' (ibid., p. 22) *horizons*. These horizons are socially constructed and can become expectations and aspirations that underlie and motivate social action, influencing the choices people make and the possibilities they seize. Thus allowing examination of both the specific options and the general patterns of decision-making that appear within these 'socially structured zones of possibilities', vital conjunctures are 'manifestations at once of recurring systemacity and of unique possibility and future-orientation' (ibid., p. 24).

This duality of systemacity and uniqueness makes the concept of vital conjunctures particularly suited to the study of reproductive interruptions – where the prefix *vital* is even more salient since the life and death of both mother and foetus are often critically at stake.[25] First, *all* forms of interrupted fertility can be systematically considered vital conjunctures in that they potentially distort old patterns of meaning and require new orientations towards the future. In Johnson-Hanks' terms, they entail 'specific periods of potential transformation' (2006, p. 22). *Potential* here means that not every interruption necessarily generates major transformations. Some interruptions do; others don't. Some become disruptive events; others are downplayed as non-events. But

irrespective of the degree of disruption experienced, *all* cases of interrupted fertility involve women (re)considering their previous pathways and their current stakes and ambitions (or, in Ortner's words, their 'projects') in the face of different horizons into the future. The concept of the vital conjuncture sheds light on the social mechanisms of decision-making and meaning-generation that precede, form, and follow these interruptions – irrespective of the particularities of the event. The breadth of the concept thus bridges the dichotomy of miscarriage and stillbirth as well as that of intended and unintended interruptions.

Second, the concept of vital conjunctures allows investigation of the *particularities* that constitute women's experiences of interrupted fertility. This 'unique possibility' is comprised of the particular situation a woman finds herself in when facing a reproductive interruption as well as the specific combination of horizons and constraints this situation presents. Among the large number of possible 'paths' that a vital conjuncture presents, only a small number are more or less *likely* to be followed. Which steps are finally taken depends upon many specific conditions and is highly *contingent*. By focusing on the contingencies that inform vital conjunctures around reproductive interruption in the East of Cameroon, the current study 'situates' (Greenhalgh, 1995) reproductive decisions within their specific contexts; it thus aims to overcome the dichotomy between structure and agency.

Given the interrelation between a woman's actions or choices and the surrounding contingencies, it follows that each vital conjuncture is in some way unique. Each new situation offers other horizons, relational advantages or disadvantages, perspectives on previous pathways, and possibilities to manage or adjust one's 'projects' for the future. Not only do specific local and relational contexts change over time; wider ongoing transformations – such as developments in medical technologies, state policies, and global economic trends – also affect the possibilities and constraints women face. For the specific context of Cameroon, Johnson-Hanks (2005) argues that both these micro- and macro-surroundings have become highly unpredictable. People's constant mentioning of '*la crise économique*' and '*la crise morale*' shows how their experiential uncertainty pervades all domains of life. Johnson-Hanks argues that in these circumstances, effective social action cannot be based on the fulfilment of prior intentions, but is rather accomplished through what she calls *judicious opportunism*:

> While my interlocutors are explicit about their withdrawal from prior intentions (…) they nonetheless engage in effective action in the moment, recognizing and seizing opportunities as they come. The challenge is not to formulate a plan and implement it regardless of what comes but to adapt to the moment, to be calm and supple, recognizing the difference between a promising and an unpromising offer. I call this alternative to rational choice "judicious opportunism" and suggest that it is widespread in social action, both in sub-Saharan Africa and in the rich West, whenever the social structures that enable and enforce rational choice are absent or weak (2005, p. 370).

Instead of having clear trajectories in mind, people often take promising chances – informed by the multiple horizons, relational advantages, possible new projects, or discursive norms that come together in the vital conjunctures around reproductive interruption. As multiple and often contradictory opportunities give rise to uncertainty and ambivalence, the current study examines how women tactically 'navigate' (Vigh, 2006) such ambiguous vital conjunctures around interrupted fertility.[26] By placing decisions within a wider frame of possible options, it carefully situates women's explorations of different horizons, and the inconsistent alteration of pathways and projects that underlies this navigation. The inherent uncertainty of this process is wonderfully captured by Whyte's (1997, 2002) concept of 'subjunctivity'. To understand the 'elements of contingency, indeterminacy, and ambiguity' which underlie matters of health and illness, Whyte proposes to 'follow people as intentional subjects engaging each other and the contingencies of their lives in a mood that is often more subjunctive than indicative or imperative' (Whyte, 2002, p. 172). Subjunctivity is defined as:

> a way of focusing on the intentions, hopes and doubts of people looking toward an immediate future whose concerns [a]re not certain. I pointed to the situated concerns of subjects facing problems and to the directionality of their efforts. Subjunctivity is not just about uncertainty; it helps us attend to purposes and consequences. It asks us to take seriously the question of what people are trying to do (Whyte, 2002, p. 186).

Attention to individual and inconsistent intentions that are at the same time *situated* concerns touches on the question of the social embeddedness of reproductive experiences and decisions. How is a woman's navigation of a vital conjuncture inspired by personal aspirations and subjective experiences, and to what extent are these *influenced,* or even inherently *constituted,* by a web of interpersonal connections? While Johnson-Hanks does not specifically address this issue, current Africanist debates do so in their theorizations of the inherent sociality of bodies, selves, and personhood in African cultures. A dominant argument in this debate posits that experiences and decisions should not be situated in the individual body or mind alone, but comprehended within the framework of a *social body* that *interconnects* and *integrates* the self with its social relations.[27] Considering the body 'as a relation among bodies' (Piot, 1999; T. Turner, 1994, p. 44, 1995), its proponents suggest that realities and experiences in African settings are by default socio-centric rather than ego-centric. Such a view identifies social others as key contributors to individual health and illness, for instance; bodily well-being is perceived as dependent on, and vulnerable to, the feelings, wishes, and interventions of others. Physical symptoms merge with social distress; decision-making around these symptoms is thus an *inherently* social affair. This is deemed to be particularly true for fertility matters, where interrelations between bodies are *sine qua non.*

Critics of this socio-centric view of personhood and decision-making have drawn attention to the existence of different modalities of personhood in both African and non-African cultures.[28] They argue that even in the most relational realities of African daily life,

forms of individuality are often acknowledged. Michael Jackson and Ivan Karp, for instance, argue that 'worldviews which stress the ontological priority of the collectivity do not prelude the countervailing experience of biographical uniqueness' (M. Jackson & Karp, 1990, p. 27). For West Cameroon, Nyamnjoh (2002, p. 115) has pointed out that within the social world emphasizing interconnectedness, individuals *do* have the freedom to pursue personal goals and to be creative. Yet, with agency being 'domesticated' – that is, always existing within and depending on a socially predetermined frame – the question is how the individual and the social are negotiated in any process of achievement.

With its focus on women's navigation of socially constituted reproductive conjunctures, this study will touch on the questions raised in this Africanist debate and try to formulate specific answers to them. By exploring the (degree of) sociality of pregnant bodies and reproductive decisions in a Cameroonian village, it will moreover complement the framework of vital conjunctures in two ways. First, the examination of the sociality of female *bodies* will draw attention to the physicality of pregnancy and its interruption, that would be overlooked if the focus would be merely on women's decision-making. Reproduction and its interruption are instrinsically tied to the body's (in)capacity to conceive a pregnancy and bring it to term, and although women (and others) may use different methods to influence the physical course of events, their reproductive navigation is circumscribed by these bodily workings. This physicality will be studied in context; I will explore how it changes with the development and expulsion of the foetus, and within different social situations, times, and places. Such a focus will foreground women's embodied, lived experiences of pregnancy and its interruptions (Biehl et al., 2007; Csordas, 1990, 1994; M. Jackson, 1998), preventing a mere mentalist representation of the choices and actions surrounding reproductive happenings, of which Johnson-Hanks could be accused.

Second, the focus on questions of sociality and individuality can also deepen our understanding of these choices and actions, for it sheds light on more general patterns and dispositions that underlie reproductive navigation. While the notion of vital conjunctures makes insightful the ambiguities, complexities, and inventiveness surrounding reproductive happenings, it risks arriving at a relativist stance where 'everything is contingent on everything'. This at least seems to be Johnson-Hanks' conclusion. Though she presents a set of different horizons – the scenarios of the 'murderous abortionist', the 'falling schoolgirl', and the 'glorious bride' – that direct the choices of Beti school-going women during their first pregnancies, it is unclear *why* certain women cling to one horizon, while others orient themselves towards another. The exact (inter)personal dynamics that underlie specific choices remain under-analyzed (see Slama, 2007, for comparable criticism).[29] Rather, the outcomes of women's vital conjunctures are presented as a matter of pure contingency and judicious opportunism.

In exploring more general modalities of individuality and sociality in Gbigbil society, this study aims to go beyond such a conclusion. It posits that the

acknowledgment of contingencies should not preclude investigation of how certain modes of collectivity or distinctiveness *do* make women more or less liable to choose certain horizons from the outset. Here I agree with Jane Guyer, who once discussed Johnson-Hanks' concept of judicious opportunism in *Current Anthropology* (2005, p. 379). Guyer asked whether and how we could search for 'new aspects of "ordering" out of apparent randomness' that seems to pervade (women's navigation of) states of 'routinized uncertainty' in Cameroon. One of her suggestions was to investigate whether there are 'specific forms of sociality that optimize the occurrence of promising novelties' that women encounter in their vital conjunctures. In other words, Guyer proposed to find out if and how the appearance – and women's explorations – of certain horizons could be related to the particular webs of social relationships in which women are embedded.

This dissertation takes up Guyer's challenge. I intend to improve the framework of vital conjunctures by focusing on the particular make-up of the pathways that women had embarked upon before their pregnancies got interrupted, and of their particular *projects* – that is, their ambitions, aspirations, and hopes for the future – when reproductive interruption(s) 'cross their path'.[30] The aim is to unravel certain – social, but also individual and physical – characteristics that *from the outset* define which promising chances are possible for, and possibly taken by, my informants during such reproductive conjunctures. In doing so, I seek to provide more solid ground for understanding *why* women switch from one pathway to another when faced with interrupted fertility – and which social, individual, or bodily characteristics seem to influence this reproductive navigation. This, in turn, will lead to deeper insights into the relevance (or irrelevance) of reproductive interruptions in women's daily lives, and the ways in which social relationships, personal aspirations, and material bodies contribute to their outcomes.

Outline of the dissertation

This thesis will situate women's experiences and decisions around reproductive interruption within the particular relational and wider contexts that make up the conjunctures around these happenings. In order to make sense of the processes of navigation in these moments, I focus on women's previous *pathways* (i.e. their life histories) and *projects* (i.e. their ambitions, aspirations, and hopes for the future), as well as the interrelationships of these pathways and projects with social norms and networks. Different pathways and projects thus form the red thread through this dissertation, which is divided into two sections: the first sketches the contexts of fertility interruption; the second focuses on the actual reproductive conjunctures – where past pathways and present projects are possibly reconsidered – that form the focus of this study.

The first two chapters depict the environments in which Gbigbil women experience, interpret, and manage their reproductive conjunctures. Chapter 1 situates the women and their stories within wider social, political, and economic 'terrains'. It describes the many issues, transformations, and social structures relevant to understanding the

possible pathways and reproductive projects of my informants in Asung. First, a local 'map' of the village will set out the many unstable terrains that people navigate in their daily lives, and that frame the navigation of reproductive conjunctures in particular. Second, the chapter traces the development of public and reproductive health services in Cameroon and shows how (inter)national population and health policies have affected the health care options and constraints women encounter on their personal paths. The chapter ends with methodological and ethical reflections on doing anthropological fieldwork within these national and local contexts that are, as Johnson-Hanks once noted, characterized by a 'routinized state of uncertainty' (2005, p. 376).

The next chapter focuses on specific reproductive ideas and practices that exist in the field. It describes what it is like to be pregnant, to give birth, and to become a mother in this rural part of East Cameroon, and explores ideas on when, how, and in what contexts motherhood should be achieved and could become endangered. Shifting perceptions of what a pregnancy is, how and when a 'child' is formed, and what kinds of medical surveillance this gestational process requires inform the social sorrows and individual manoeuvres that pervade the antenatal phase.

Having outlined these contexts, the second part of the thesis then focuses on particular vital conjunctures around reproductive interruption. The chapters in this section will explore the interpretation, navigation, and outcomes of these conjunctures – and how these are related to women's previous pathways and present projects. Chapter 3 focuses on reproductive interruptions that occur during women's pathways towards productive and reproductive status within the village. It explores how fertility interruptions affect women's ambitions to be hard workers in the fields, as well as good wives, mothers, and daughters-in-law. This chapter shows how village women, when deprived of their reproductive capital and horizons to alternative forms of social status, redefine their projects and positions during these critical reproductive conjunctures.

Chapter 4 illustrates how women deal with reproductive interruptions when fertility is *not* their only or primary project, but when they had chosen to explore horizons of schooling, employment, or rich partners in urban areas instead. The chapter shows how reproduction and its interruption are managed when women had envisaged their pathways to lead to urban respectability; it situates women's reproductive decisions within this wider frame of projects, as well as within local ethics of kinship and marriage that continue to portray fertility and the conjugal framework as the ultimate pathways to respected womanhood.

After having examined *why* women make certain reproductive decisions once particular pathways seem endangered by fertility interruptions, Chapter 5 will illuminate *how* such reproductive decisions are negotiated and justified within webs of social relationships. It will show that even if their particular pathways and projects differ, women use similar discursive tactics to attain their goals. A comparison of two women with apparently opposite life stories and reproductive experiences – an older infertile

woman who has established herself in the village and a young aborting woman who aspires to an urban future – reveals how tactical deployment of ideas about suffering, fate, and powerlessness pervades *all* reproductive conjunctures, and paradoxically creates room for manoeuvring and manipulation.

In light of the diversity and ambiguity of reproductive conjunctures and their outcomes, the chapters in the dissertation's second section critically reflect on the afore-mentioned dichotomies of miscarriage versus stillbirth (Chapter 3), intended versus unintended interruptions (Chapter 4), and suffering versus agency (Chapter 5). Yet, the ultimate aim is to find meaningful patterns underlying the diversity and ambiguity. In the conclusion, I return to the nexus with which I aim to solidify the framework of vital conjunctures: the one between body, self, and society. In answering the questions raised in this introduction – why women navigate the uncertain conjunctures around reproductive interruptions in particular ways – this final discussion will focus on how reproductive projects and pathways are *affected* by social others, *asserted* by individual Gbigbil women, and possibly *altered* by women's bodies. By analyzing the kinds of sociality, individuality, and physicality involved in women's reproductive navigation, this study aims to improve upon the existing framework of vital conjunctures and further our understanding of human reproduction and its interruption.

PART I: CONTEXTS

1. ASUNG, *AIRES DE SANTÉ*, AND AMBIGUITY: ON LOCAL TERRAINS AND THEIR TENSIONS

It is October 2004, just a few days after my first visit to Cameroon.[1] *I find myself in the company of Filbert, his older brother, and a priest in a rather defective car grumbling under the high speed with which we are driving through the rainforest. All three men originate from the village in the East Province that we are heading to and that is to become my fieldwork site, but they live in urban areas now, where they found formal jobs years ago. Proud to return to their village in order to introduce me there, they fill the one hour trip with exciting stories and recommendations about village life, loudly uttered against the background of upbeat popular religious music. The noisy joyfulness inside the car contrasts with what I witness outside: extended terrains of natural beauty and silent, dense forest, interrupted by groups of mud huts, which gradually disappear in the darkness of the suddenly falling night; only the cooking fires still reveal the presence of human settlements from time to time.*

Suddenly, in the midst of the darkness and music, the three men simultaneously announce that 'we have entered the village now'. Noticing my surprised look, searching for cooking fires or other signs of human presence, Filbert laughingly clarifies, 'At least this is our terrain. Land is not lacking here. It is our wealth. All you see around us belongs to the Gbigbil people. They have their fields here on which some even sleep or temporarily live'. His elder brother relates how people used to live like that: scattered through the forest. Their current habitation alongside this road is actually the result of governmental pressure, he informs me. The priest comments that thanks to the abundance of land, the village is still growing and developing; people aim to exploit their only source of wealth by bearing many children that will occupy this vast area – just as God had demanded.

Listening to these animated discussions I notice how, after what seemed a never ending tour through the vast and dark 'terrain', cooking fires again surround us and announce our arrival in the 'centre' of the village. With the men still discussing governmental pressure and Godly inspired fertility, we come to a halt in front of my house-to-be – the local health centre – which seems to be the only visible presence of government as a lighted, brick place amidst dark mud huts and cooking fires. When I pass alongside the building with my bags I see how the light bulb at the entrance of the hospital illuminates posters promoting HIV/AIDS prevention and family planning. The silence that surrounds this health centre again contrasts with the loud joyfulness I encounter inside the patients' ward where I will take residence during this first fieldwork period – with the doctor's many children curiously surrounding and greeting me and the baby on his wife's back anxiously starting to cry at my sight. With a smile on my face and the help of Filbert, his brother, and the priest, I settle down in the village that I will continue to visit long afterwards.

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While Filbert's car brought me into the village of Asung, the first part of this dissertation will continue the journey through the local terrains – not only the physical terrain of the village and its environments that Filbert pointed at, but also the metaphorical 'terrain' that Vigh (2006, pp. 37-38) talks about. In its metaphorical sense, a 'terrain' connotes a socio-political environment that is 'non-transparent and in motion rather than transparent, solid and stable' (ibid., p. 12). More than, for example, the notion of 'field' (Bourdieu, 1977, 1989), a terrain captures the constant shifts of structural organizations that people create, attempt to make sense of, and 'navigate'. As the two chapters in this part of the dissertation – exploring the contexts of Gbigbil women's reproductive conjunctures – will show, the terrains in which I did research and in which Gbigbil women experience and manage fertility interruptions are highly unstable and unpredictable. Political corruption, economic decline, deteriorating health perspectives, social transformations, and contradictory discourses pervade all levels and domains of life; they affect people's immediate praxis and their imagined worldviews. These actions and horizons, in turn, direct the navigation of vital conjunctures around pregnancy interruption – which will be described in the second part of this dissertation.

The current chapter aims to describe and historicize different features of daily life in Asung. Next to the fragile political constellations, economic insecurities, and sanitary insufficiencies, I will describe the local kinship and marriage arrangements, as they are omnipresent – in discourse and in praxis – and of major importance in reproductive happenings. I then focus on the terrains of national and international health policy-making and intervention, which likewise frame women's reproductive health behaviour. I will show how Cameroon's official rhetoric on reproduction and health care clashes with the lived experiences in Asung as well as the expectations of the international reproductive health arena. The resulting practical messiness directly affects the options and obstructions women encounter on their reproductive pathways.

Obviously, the distinction between these different levels and terrains is just an analytical one; in daily practice, it is rather their indistinctiveness and interdependence that makes life hazardous and complicated to navigate. In the last part of this chapter, I outline how I as a researcher 'navigated' this daily life complexity, and tried to make sense of it methodologically, but also personally and emotionally.

'*On cherche la vie*': making a living in Asung

Asung is a Gbigbil village in the rainforest area of East Cameroon that looks like many other settlements in the region, though it might be a bit larger than surrounding villages; it embraces 1,000 of the approximately 6,000 people belonging to the Gbigbil ethnic group.[2] Their terrain stretches over many square kilometres of green hills, and even the

'centre' of the village covers almost four kilometres of thatch- or iron-roofed rectangular mud huts, regularly spread alongside the paved road. Every house is surrounded by one or more separate kitchens and a hangar (an open, thatch-roofed shed) in which people rest, cook on fire, eat, or discuss. Pigs, chickens, goats, and dogs roam around, lie down on the reddish earth, or anxiously disperse for the rare traffic that passes on the road – often with a speed that is amazingly high considering its overload. The street is further filled with children, some with books on their heads while running to school, others carrying pans with *rôti* (humps of bush meat) that their mothers prepared and sent them out to sell; women who return home from the field with their production of the day in huge *bassins* on their heads; and men who, armed with their machete or gun, go out for hunting, or patiently wait at the roadside with their self-brewed *matango* wine for a rare occasion of transport to take them to the market in the nearest town of Bélabo. Striking is the peaceful but lively character of the village and the constant flow of greetings that are exchanged between people in the hangars and those passing on the street.

Photos 1a and 1b Typical views of Asung, with huts and hangars situated alongside the paved road

Although this daily life scenario may seem timeless at first sight, the current village construction is of recent origin. The layout of fixed groups of huts ordered alongside a central road forms a major contrast with the itinerant history of the Gbigbil. Until the end of the nineteenth century people did not establish themselves for a long time in sedentary settlements, but led a semi-nomadic existence in the sparsely populated rainforest area.[3] Constant mobility prevented assemblies from becoming too extended; moving groups consisted of male family members and their followers, which were flexibly reconstituted along with conflicts, wars, raids, pacts, friendships, and alliances. To become an adult and respected man at those times was to separate oneself from the group, create an autonomous settlement, and become the chief of a new family unit. Power and respect depended on the number of followers one could subsequently subject to himself – a 'wealth in people' principle that has been described for many neighbouring groups as well (Copet-Rougier, 1985, 1987; Geschiere, 1982; Guyer, 1984; Johnson-Hanks,

2006; Laburthe-Tolra, 1981). Central authorities were nevertheless absent in the region; although some men would try to gain wider influence on the basis of their personal traits or talents, power would not get into the hands of one single person easily or for a long time, and chiefs did not have much authority beyond the village level. Even if hierarchies were always present, they were never institutionalized in the 'segmentary' Gbigbil society or elsewhere in the East and South Provinces – thereby forming a huge contrast with, for instance, the centralized *fondoms* in the Western part of the country (Geschiere, 1997a).

Only towards the end of the nineteenth century did more permanent settlements seem to develop, in which economic and political differentiations became more clearly established. The long distance trade of different commodities that was initiated in this era enabled those controlling the flow of products and money to acquire a larger number of wives and followers than others. Several sources have noted how the development of big polygamous households brought an end to the former mobile lifestyle that had reigned in the region, while the long-standing principle of social relationships as an important source of power persisted and allowed these villages to expand (Abega, 2007; Billard, 1961).

It remains unclear to what extent this long distance trade (originating from the West coast of Cameroon) and the reported ensuing expansion and establishment of groups really affected the Eastern region in which the Gbigbil lived around the turn of the century. But local stabilization and internal hierarchization certainly happened after the arrival of the German colonizers in the area around 1910. The Germans, and later the French, created fixed villages that were made accessible and controllable through road connections; they appointed village chiefs who would function as intermediaries between the Europeans and the local people; and they constructed schools, hospitals, and agricultural centres in the communities. This happened especially in the Gbigbil village of Ibudim, which therefore attracted people from surrounding villages. One of Asung's current *sous-chefs*, famous for his good recollections of that era, once drew the map of the old Ibudim for me. Figure 1 shows the presence of a hospital, public market, school, and agricultural centre towards the north, *chefferies* of different lineages in the centre, and some ancient routes, rivers, and settlements of different families towards the south.

Figure 1 Ancien village *of Ibudim*

After a short period in which the annexed region seemed to flourish, the Gbigbil population was drastically reduced from 1935 onwards.[4] The reasons have been sought in the massive rural exodus at the time, as well as the endemic diseases and high child mortality that raged through the area and were fought first by the German and later the French colonizers (Mengue, 1982).[5] The region inhabited by the Gbigbil population – as well as the wider East region of Cameroon – came to be represented as under-populated and underdeveloped by the colonial and post-colonial regimes.

Although the area is currently still characterized by immense, sparsely populated natural terrains, the Gbigbil population increased again after 1967. This is exactly the year of the massive forced migrations from what are now called the *anciens villages* – or *ilīk* in Gbigbil, meaning 'what we have left behind' – to the new locations eleven kilometres westwards, alongside a newly constructed road between Bertoua and Bélabo. Due to the low population density in the area and for administrative purposes, the post-colonial Cameroonian government forced separate residential units to merge into bigger agglomerations (Abega, 2007, p. 37).[6] As such, two Gbigbil *anciens villages* (called Ibudim and Imanduka) that had previously led a separate existence were now forcibly joined into the village I call Asung. The map of the current village construction, drawn by my informant mama Rosie (Figure 2), clearly shows the ordered way in which houses, churches, schools, *chefferies*, and the health centre have been constructed alongside the main road.

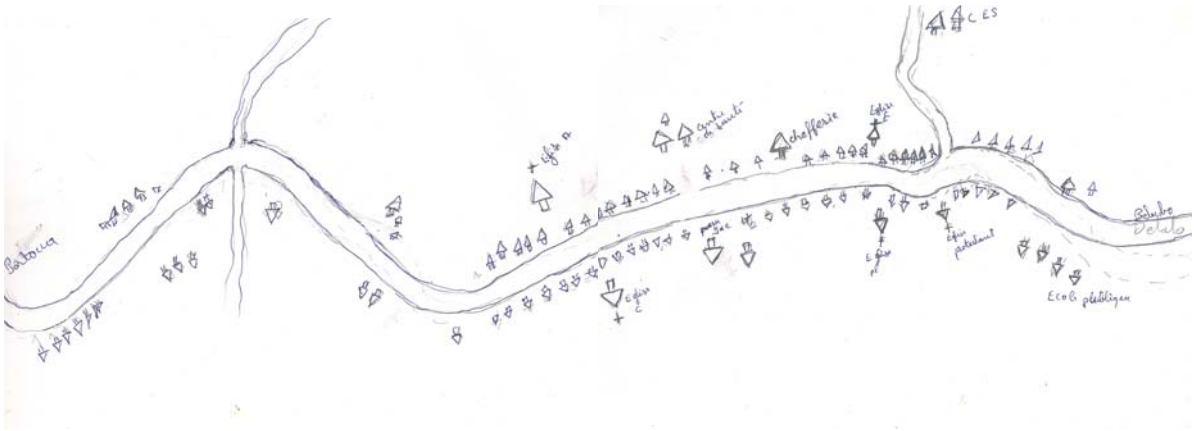

Figure 2 Asung, built alongside the road constructed in 1967 between Bertoua and Bélabo

This relocation did not happen without struggle or resistance; people still remember how some were attracted by the promise of 'development' and prosperity at the new location, while others hid on their fields and only gradually started to move their belongings from the old to the new settlements. Old compositions of and relations between villages and lineages were drastically changed. Not only were they joined together or torn apart, but they also had to partition the new terrain that surrounded the paved road – which they did mainly on the basis of kinship principles, with different lineages receiving different plots of ground. Frictions and fights around this division of land made several 'brothers' decide to separate from the main group – just like in former times when conflict threatened the harmony of the group – and establish themselves with their families at some distance from the 'centre' of the village. Some created the hamlet Bitamien (an Ewondo word meaning 'let us first try to see') that is presented at the left margins of Figure 2. Others founded the neighbourhood of Akepa (named after the river in that area) at ten kilometres from Asung.[7]

On these new locations, public services (re)developed and governmental influence became easier and more visible. Currently, Asung has a kindergarten, a primary school, and even a secondary school. In the centre of the village a dispensary (*Centre de Santé Intégré*) including a maternity ward can be found, rehabilitated with the help of an Italian Cooperation (AFMAL). However, as national health services gradually deteriorated since the economic crisis in the 1980s, the clinic is regularly out of service; electricity and water supplies are scarce, and health personnel and medicines are only intermittently present. Nurses who received some form of medical training are appointed to and removed from the centre on an irregular basis, leaving the hospital in the hands of an uncertified local pharmacist and an auxiliary nurse. They do not only bear the responsibility for the medical care of the inhabitants of Asung, but also receive patients from the six other villages that belong to its 'health area' (*aire de santé*) – a region covering a total population of 6,832 people in 2009.

The many revisions in policies, interventions, and supply of personnel at the health centre have made village dwellers quite sceptical and distrustful with regard to its services; not only patients at the outskirts of the *aire de santé* – situated at a distance of more than ten kilometres from the centre – but also neighbours residing in Asung often do not even bother to visit the dispensary in case of illness. The afore-mentioned silence I perceived during the night of my arrival in the village was also not exceptional for daytime. Especially when the doctor was unexpectedly absent, the place would be deserted for days on end – with the few patients who had come from afar leaving immediately again. When I arrived a few years later for a second fieldwork period conditions had worsened: the health centre had been completely abandoned and was now surrounded by fences to prevent the goats from destroying the surroundings and polluting the entrance hall – where the same posters as before were surrounded not only by silence but also by complete darkness since nobody was left to switch the light on at night. [8]

For this reason, many people prefer to use the sanitary services of the Roman Catholic missionary station in the neighbouring village of Kamandjom, headed by Italian and Brazilian sisters.[9] Fares are sometimes lower and medical services better and more consistent. The sisters also organize educative workshops on food preparation and hygiene for pregnant women, young mothers, and HIV positive people. Although nowadays people of all religious backgrounds are accepted and treated in the missionary health station, the care remains strongly guided by Christian principles; family planning advertisements and services are formally absent.[10]

While the attractiveness of the missionary educational and sanitary services might have been an impetus to convert to Christianity in former times (Laburthe-Tolra, 1999), a trend of religious polarization and diversification is currently visible in Asung. Next to the Roman Catholic, Presbyterian, and the Adventist churches that have a long history in the village, there is an increasing manifestation of new congregations such as '*Mission du Plein Évangile*', '*L'Église Évangélique Luthérienne*', '*l'Église Messianique*', '*Parole Parlée*' and '*La Vraie Église*'.[11] Yet, alongside and within these religious institutions and practices, all sorts of beliefs with regard to spirits and witchcraft play an important role in Gbigbil daily life. Witchcraft stories are abundant in the village; most of the time, they relate how greedy human beings transform themselves into evil spirits in an invisible world (*mgbəl*), where they enrich themselves by eating the flesh and sucking the blood of their fellow human beings – who thereupon die in the 'visible world'. They do this alone or in nightly group gatherings; what counts is that only those who were born with the power of witchcraft (*ivū*) in their bellies can participate and 'see' what is happening in this other world.[12] This occult power and the resulting capacity to 'see' can, however, also be drawn upon for good ends, like combating evil or healing afflictions (de Thé, 1970; Fisiy & Geschiere, 1993; Geschiere, 1982; Mallart Guimera, 1981). Witchcraft is thus an ambiguous power – forceful and most of the time also fearful.

Syncretism has led to a situation in which worries about the wrath of God, witchcraft attacks, and ancestor punishments are co-existent and often intertwined; to offer food and drinks to the grave of a dead relative after having gone to the church and while wearing protective amulets against the evil eye of witches, is not at all an exceptional scenario in Asung. This variety of beliefs and practices pervades the domain of health and well-being as well. For Gbigbil people, healing can happen after consultation in a health centre, during a prayer session in church, with the help of ancestral herbal knowledge transmitted by a dead relative in a dream, or through the supernatural interventions of a *marabout.* Problems with *reproductive* health are equally complex and associated with different realms, as we will see in the chapters that follow.

Heterogeneity is also perceptible in the economic realm. Paramount is the daily work in the numerous fields that surround the village – situated 'in the backyard' or far away in the bush. Activities in these fields are contingent on the two dry and two wet seasons (*isəb* and *mbule*) and are strongly gendered. While men are responsible for the heavy clearing and burning of the fields – obtained through slash and burn methods – women manage, quite independently, the subsequent production of, *inter alia*, corn, cassava, cocoyam, groundnuts, fruits, and vegetables. Thus, after husbands grant a plot of land to their wives and facilitate the commencement of their work on it, it is the latter's responsibility and source of pride to come back with an abundant field production and prepare rich meals for all the children, men, and strangers in the family. However, this subsistence economy on which daily life is largely based does not suffice to cover extra expenses or satisfy other basic needs. Money is needed for children's schooling, hospital expenses, clothing, bride-price transactions, or for basic products such as soap, salt, or petrol to light the oil lamps at night. Such products can be bought at the three small shops (*boutiques*) in the village or at the weekly market where outsiders – mostly female *bayams* coming from the North of Cameroon or Yaoundé – offer these basic provisions at a lower price.

To meet these ends, both men and women engage in some income generating activities. Many women capitalize on the production of their fields; they try to earn a little money by preparing and selling dishes 'on the street', or by trading their surplus products at the weekly village market or at the bigger daily markets in Bélabo. Some brew local wines and whiskeys, which they sell at home or at the market. Men also go to markets to sell their self-brewed *matango* and *mbang mbang* wines, or hunted game. While some older men used to own big cacao or coffee plantations around the *anciens villages*, the considerable wealth and respect they formerly enjoyed has faded away since the devaluation of these products on the global market from the mid-1980s onwards.[13] Therefore, especially young men increasingly create their own fields or work on those of their wives in order to produce cash crops such as plantains, pineapples, bananas, and palm kernel. However, the income from these cash crops fluctuates heavily and has become insecure in current times of economic crisis. Though outbursts of protest were

never as violent in Asung as in Yaoundé during the riots in February 2008, the despair of villagers at that time was great since *bayams* simply abandoned the village for weeks on end – leading to a collapse of the local market and people's precarious revenues.[14]

In these days of economic insecurity and political disengagement, where the only reality for people is just '*le quotidien de chacun*' ('everyone's day-to-day experience') (Moupou & Akei Mbanga, 2008), mutual support groups have developed in order to communally strategize and anticipate the future. In Asung, two official *Groupements d'Initiatives Communes* (GICs), created by the non-governmental organization 'PLAN International', assemble village women under the headings of 'we search for a life' (*seying ining*) and 'the grain of cucumber' (*sol ngon*).[15] Further, many informal '*associations*' have been formed by women or men of a certain neighbourhood who unite themselves for work in the fields, for mutual assistance in case of misfortune, or for weekly *cotisations* in which small amounts of money are saved and distributed. Though these village initiatives might bring alleviation for some, others prefer to – more or less permanently – escape the insecurities of rural life by 'searching for a life' ('*chercher la vie*') in urban areas. Only rarely do they manage to find a formal job; most end up in the informal sector or petty trade (see also Chapter 4). Those who do succeed, however – like the men who brought me into the village – end up in ambiguous positions in their natal village: on the one hand, they are respected for (and constantly reminded of) their success, their entrance into patrimonial networks, and their role in the village's development; on the other hand, they are vulnerable to accusations of witchcraft or sorcery by kin and non-kin alike (Fisiy & Geschiere, 1993; Geschiere, 1982, 2003; Nyamnjoh, 2002). In the light of the egalitarian norms that have long pervaded social life in this region, those who raise their heads above the others are easily suspected of achieving their positions by means of supernatural, antisocial forces.

Not only do rapid economic and political changes and uncertainties lead to the movement of Gbigbil people to urban areas, but other ethnic groups also enter the village in search of a better livelihood. More and more Muslims from the North of Cameroon come to settle down and offer their paid labour force or try to initiate commerce. The arrival and integration of these different ethnicities has created a diversity of languages and dialects in Asung; next to the local language of the Gbigbil people – which carries the same name as the ethnic group[16] – almost everybody uses the French language as a *lingua franca* when communicating with old and new neighbours, when negotiating with *bayams* on local markets, or when travelling to relatives in urban areas.[17] Asung is a village characterized by diversity, complexity, and mobility – not only as a result of an itinerant history and a dynamic present, but also due to complex marriage and kinship relationships. These will be discussed in the next section.

'A daughter is to be shared': marriage arrangements and kinship idioms

The Gbigbil people in Asung are subdivided into nine extended patrilineal families (*metum,* singular *atum*), of which the most prominent is the Bibakung lineage. Members of an *atum* live together in a spatially demarcated neighbourhood, called *quartier* in French or *itounsung* – which literally means 'small village' – in Gbigbil. These *quartiers* are inhabited by the male descendants of a mutually recognized ancestor, the women who have married and, according to virilocal rules, settled into the patrilineage, as well as their sons and unmarried daughters.[18] Most of the *metum* in Asung intermarry, but exogamy is prescribed with regard to the kin groups of both one's father and one's mother. The official rule traces predecessors of both parents into the fourth generation and forbids marriage between all respective descendants (see Onambele, 1995 for a similar conception among the Ewondo). Even if, in practice, this rule seems more complicated (with exceptions on the matrilateral side possible) and more contested (especially when members of the third or fourth generation have already died), its non-adherence is generally believed to result in the death of the partners or their children – a misfortune that can only be prevented through the dissolution of the marriage and the performance of the traditional rite called *isam*.[19] Knowledge of genealogies is thus deemed indispensable, especially in the search for suitable marriage candidates. *'One ngon/mo nye?'* ('of whom are you a daughter/son?') is the initial inquiry in this respect, followed by the question *'niaŋa ane ngon nye?'*, meaning 'of whom is your mother a daughter?'.

This genealogical knowledge was important in historical times, when the capacity to trace a common ancestor could save lives when two migrating families would be confronted with each other. It would furthermore inform whom to perceive as an unrelated possible enemy, with whom war or bonds of friendship and marriage could be initiated. Due to the rule of exogamy, it was only among those with whom war was possible – i.e. non-related groups – that potential marriage partners were to be chosen (Abega, 2007, p. 44). A local saying indicating that 'marriage is war' ('*abal ine meluma*') tellingly reflects this precarious situation.

As a result, marital unions have always been fraught with ambivalence – caused by the relationship of dependence between possible foes. The position of a (newly) married woman in particular is pervaded by ambiguity: for the family of the man, she is a (potentially dangerous) outsider on whom they depend for the continuation of their lineage; for her own family, she becomes an outsider as well, since she has left her paternal home and bears children for another family. The Gbigbil adage relating that 'a daughter is to be shared' ('*mon munka ane komaka*') points to these dual stakes. Never really 'belonging' somewhere, a married woman thus faces ambivalence and frictions – feelings of hostility and solidarity – with regard to, and coming from, both families (Bonnet, 1988; Copet-Rougier, 1985; de Thé, 1970; Geschiere, 1982; Houseman, 1988).[20] Contestations centre explicitly upon the *reproduction* of a married woman – being a

descendant of one family but bearing descendants for the other, while the number of successors is a major source of social status for both parties.

A married woman's fertility has thus been conceptualized as one side of a reciprocal relationship. Her family can ask compensation for the 'loss' of their daughter and her childbearing capacities to an unrelated group. This compensation – several gifts, social duties, and bride-price payments over time – creates an enduring reciprocal alliance between the lineages and appeases the inherent ambiguities of the exogamous marriage rule. While in former times the exchanged commodities were arrows, lances, cowries, food, and animals, nowadays they include money, red wine, clothes, blankets, food, and small animals. People have clear ideas and ideals about when and how certain presents should be given and reciprocated. Apart from the many small gifts which constantly confirm and conciliate the ambiguous alliance, they mention five major transactions: the wine of presentation, the wine of birth, the money for the mother, *kanako,* and the eventual bride-price.[21]

Ideally, a man (and his family) should initiate engagements by introducing himself (*'aza leeta njol';* 'he comes to present his body') to the family members of the woman with the 'wine of presentation' and some food, asking for permission to start a 'friendship' (*wangang*) with their daughter. After having excluded any line of relatedness and assuring their daughter's approval, the woman's relatives might then send their daughter for some weeks into the family of this man (*'keki ibong wangang*'; 'go to sleep the friendship'), thus allowing both parties to explore each other's habits.[22] If evaluated positively, the woman can be accepted by her in-laws (*bekīl*) as a daughter-in-law (*ngamon,* literally meaning 'wife of the child'). Around this acceptance arises a first moment of contestation and conciliation: the woman's brothers will come to ritually demand their sister's return (*'atei sa n'abal*'; 'he refuses the marriage') and will only consent with the alliance if the new father-in-law of their sibling sends them home with a satisfying sum of money. Contestations like these show how marital arrangements are built upon, and possibly disturbed by, potential frictions between the two families.

Ambivalences also characterize the relationship between the new *ngamon* and her in-laws, especially in the first years of marriage. On the one hand, *ngamon* will be subjected to a wide array of behavioural norms and regulations, prescribing respect, compliance, and diligence. On the other, she can at all times resort to the intervention of her own family members, and publicly express her discontent with her in-laws, or even utterly insult or ridicule them during ritual occasions which allow for the demonstration of a 'joking relationship' between affines.[23] Struggles manifest themselves especially in the relationship with the mother-in-law. A newly married woman (*mom*) is obliged to cook in the kitchen of the latter and only receives her own kitchen (and, by implication, more independence) after several years of hard work and severe supervision. The exact moment of this *idang kisin* ('traverse of the kitchen') is uncertain and therefore subject to

contestation and negotiation; its final happening becomes celebrated by the visit of the woman's relatives offering diverse utensils to be used in the new kitchen.

The inherent distrust and friction between lineages is especially revealed at moments of pregnancy and childbirth. Although all the children a married woman will bear will normally belong to the family of her husband (*num*), she will go and deliver (*abial*) in her own family – especially during her first pregnancy, but often also afterwards. The underlying assumption is that she will enjoy more safety and care during and after delivery in her own family than in the (often still unknown) family of her husband, where indifference, jealousy, and witchcraft might be omnipresent. After birth, the new mother (*yal*) is only allowed to return to her in-laws once they have transferred the 'wine of birth' (*medokh meyal*), with which they recompense 'the blood that has been spoilt' and acknowledge their descendant(s). After the consummation of *medokh meyal*, *yal* will be accompanied into her family-in-law by her own family members (*'ilikla yal';* 'the accompaniment of the new mother'), offering another set of gifts to their counterparts.

Hereafter, and irrespective of the number of children borne, a woman's family expects two more transactions before the eventual bride-price (*ivoula*). First comes the *monni niaŋa bon* ('money for the mother of children'): a sum of money and other gifts that will be given to the woman's mother and the mother's sisters in order to compensate for their suffering during the pregnancy, delivery, and education of 'their' daughter. Then, people will wait for the *kanako*, consisting of gifts in duplication: one part goes to the family of the woman's father, the other to the family of her mother.[24] After these two ceremonies, it can take years before the 'real' bride-price – a sum of money nowadays set around 100,000 CFA Francs, or approximately 150 Euros – is collected and transferred.[25] In this period, the brothers of the woman can ask their brother-in-law for financial help (*'monni medom nengon',* literally meaning 'money for the brothers of the daughter') in case of problems. The money offered by the husband of their sister at these instances of request (*mepang*) will be noted down and eventually subtracted from the total bride-price sum. The transfer of this bride-price used to be a big public happening taking place in the woman's *quartier*, but is nowadays often completed behind closed doors.

According to norms and expectations, only after the complete payment of the bride-price can a formal marriage certificate – monogamous or polygamous – be signed at the municipality.[26] This certificate offers official acknowledgement of the union, as well as some security to a woman in case of her husband's decease; as a widow (*kūs*), she is entitled to stay with her family-in-law, inherit some of her husband's goods, and be buried there when she dies – which is not at all the case when women marry merely 'traditionally'. Without any marriage certificate, a *kūs* risks either being sent home or being subjected to the principles of the levirate, with the elder brother of the deceased husband inheriting and caring for the latter's wife (or wives).[27] An *acte de mariage* not only formally protects women against this – currently disappearing – custom, but it also

forms a doorway to an eventual religious marriage; only after the conclusion of a (monogamous) civil marriage can a union be confirmed in a church.

Although this ideal sequence of marriage transactions is well-known to everybody, it does not reflect the actual marital situation in Asung, nor is it likely to be an accurate reflection of what happened in the past. The quantity and quality of bride-price payments seem to have always been subject to change and negotiation (Guyer, 1986), and their instigation was also reportedly surrounded by considerable contestation in former times. Studies among the neighbouring Beti, for instance, show how men often preferred to postpone bride-price payments until they had seen a proof of their wives' fertility, or how women, behind the scenes of the patriliny, exerted considerable influence on both marriage negotiations and pre- or extramarital sexuality (de Thé, 1970, pp. 64-66; Houseman, 1988; Laburthe-Tolra, 1981, pp. 24, 234; Ombolo, 1991).

While norms have probably always diverged from actual practices, they certainly do so today. In Asung, (parts of the) bride-price payments are often delayed or completely discarded these days. Of the 174 surveyed women who considered themselves to be (or have been) married, only 31% declared that the complete bride-price had been paid. One quarter of all married women was in possession of a marriage certificate, and about one third of these (or 9.5% of all married women) had continued the ceremonies in a church (see Appendix VII). Both my informants and several studies in the region (Abega, 2007; Johnson-Hanks, 2006; Meekers & Calvès, 1997; Notermans, 1999) attribute the current neglect of marital obligations to the economic crisis which has plagued the country from the late 1980s onwards and which is perceived to severely impact men's ability to maintain prescribed reciprocities.[28] It would take them longer to assemble the bride-price or to properly provide for their wives and children in the house. Even if an effective causal relationship between economic decline and engagement into marriage – or, for that matter, the number of children born in these marriages (Eloundou-Enyegue, Stokes, & Cornwell, 2000) – is difficult to establish, what counts is that Gbigbil men and women invoke financial reasons for the postponement and neglect of formal engagements.

Consequently, many marriages in the village – particularly those of young people – are not more than informal 'trial marriages' constituted by the living, eating, and sleeping together of two partners without any establishment of reciprocal ties between both families. While exchanging food, sex, and money, both partners take time to explore each other's 'worth': women want to be sure of the good character and (financial) responsibility of a man and his family before going to 'eternalize' there, whereas men wait for a proof of women's fertility before engaging more formally (Notermans, 1999, 2004). These 'trial marriages' (*ibon*), in which bride-price payments are not yet or hardly initiated, are easily dissolved as soon as one of the partners loses interest; the separation only entails the woman returning to her own family. Local marriages are thus informal, fragile, and flexible; they offer some freedom to women and men alike. Though this

phenomenon has also been reported elsewhere in Cameroon, the incidence of informal marriages seems exceptionally high in the East Province (Calvès & Meekers, 1997).

Not surprisingly, young people often have multiple partners at the same time – sometimes just for sexual or financial rewards, sometimes with the clear aim to try and see whether the relationship could be stabilized into a 'marriage' (Calvès & Meekers, 1997; Liboko Ndabanga, 2001; Njikam Savage, 1998). But even within more stable conjugal situations – where partners live together, several children have been borne, or certain bride-price obligations have been met – both men and women often secretly maintain informal extramarital affairs. Men's adulterous behaviour is assumed natural and thus tacitly accepted; women have similar liberties due to the flexibility of marital configurations, but their behaviour should not become known.[29] These informal relationships might become formalized when a man introduces his lover as a co-wife in his polygynous household (*ival*) – a common situation that is much lamented by the many polygynous Gbigbil women in the village – or in the rarer cases of a woman deciding to move in with her '*ibon*' who meets her expectations more than her current husband. There is thus no precise dividing line between informal and formal or monogamous and polygamous marriage relationships. In a context in which everybody has difficulties 'searching his life', conjugal arrangements are characterized by secrecy, 'multiple bets', scepticism about false promises, conflicts – between partners but even more so between (possible) co-wives – and enormous mobility (see further Chapter 4).

Within this unstable marital terrain, the right to children becomes contested. The official Gbigbil kinship idiom is patrilineal: although procreative roles of both father and mother are acknowledged, children – containing blood of both parents – are said to ultimately belong to (the lineage of) their father, provided that he paid the bride-price for his wife.[30] However, since men are often neglectful or unable to transfer the demanded payments, in practice their paternity is not self-evident. Opinions about their right to children in the absence of bride-price differ; some people cling to the bride-price payments as a precondition of paternity, while most others just demand a man's acknowledgement of his paternity and (financial) care of mother and child(ren) during and after pregnancy. In this last case, the layette (*bidəl abial*; 'clothes of birth') – consisting of baby clothes, diapers, towels, baby oils, and powders – that men are supposed to give to their pregnant partners seems to almost replace the bride-price in establishing a rightful claim on one's descendants.[31] When, however, men do *not* recognize their paternity or assume financial responsibilities, women bear and raise their children in their own families. Negligent partners who come to claim their children after six years – the moment at which children are supposed to move to their father's family – are then often heavily fined or even deprived of their children, who are now perceived as belonging to the woman's patrilineage.

Next to claiming the children of their daughter *after* birth, maternal families may ask for more descendants *before* a woman gets involved in a conjugal relationship. First

pregnancies, besides being a much wanted proof of fertility, often also serve the needs for offspring of the woman's own family. The flexibility of the current sexual and marital arrangements offers room for manoeuvring to women (and their families), who can explicitly deny paternity or refuse the help of the genitor of the pregnancy in order to undermine his rightful claims to the child. Further, many women send their children to be raised by their own family members – preferably a mother or sister – in order to mediate the claims of paternity of their partner and the demands for children by their own relatives. Of 287 surveyed women, 34% stated that, contrary to prescribed norms, their child(ren) resided within their maternal rather than paternal families (see Appendix VII). These exceptions to the patrilineal rule show that kinship relations, like marital configurations, are fraught by discrepancies between ideals and reality.

The realities of Asung's daily life do not, however, clash only with *local* ideals, but also with different *national* and *international* ideologies. The following sections depict the development of Cameroon's policies on population matters, public health, and reproductive health. They will show that official interpretations and interventions are based upon many controversies, contradictions, and interdependencies – and thereby add to the tensions that underlie the current terrains which Cameroonians seek to navigate.

Public health: its promises and problems

Cameroon used to be one of the African countries whose potential for economic development was highly praised after independence.[32] Its abundance of natural resources that allowed for agricultural development and a fairly strong position on the international market, as well as its health infrastructures left by German, British, and French colonizers, inspired hopes for a future in which the country would self-sufficiently provide for the economic and sanitary well-being of its inhabitants. With almost none of this optimism left today, people cling to these promising former days, which offered them fairly well organized and state sponsored services and developments. The nostalgia of hindsight and the increasing indeterminacy of foresight make them yearn for the so-called ordered days of president Ahidjo, when hospital services were free and corruption – both inside and outside health systems – did not reign as it is perceived to do nowadays. However, as Médard (2001) has noted, this idealization of the past tends to ignore the poor management and corruption that Cameroon's health system has long known. In this section, I will depict the historical development of the Cameroonian public health sector – its successes, failures, revisions, and diversifications.

While early colonial health services were particularly focused on the army and the European population – and thus largely conglomerated in urban centres – after World War II new ideas about health and development inspired the expansion of services to rural areas in Cameroon. Health came to be viewed as an essential element and

precondition of development; a healthy population would be indispensable for a healthy labour force and thus the development (‘*mise en valeur*’) of the country. The resulting increase of expenditures on health[33] not only allowed for the development and improvement of fixed infrastructures, but also stimulated the creation of mobile health services (*Service d’Hygiène Mobile et de Prophylaxie*) which provided rural areas – such as the one in which the Gbigbil resided – with systematic medical screening and massive vaccination campaigns from the 1950s onwards (Leh, 1987; Ngono, 2005).[34]

After independence in 1960, health was one of the sectors that figured prominently in the five year plans which guided the process of nation building. However, these development policies lacked intra- and intersectorial coherence and rendered the Cameroonian health system vertically organized. Largely in the hands of former colonizers and international organizations, the approach was mainly curative and informed by absolute priorities – e.g., the fight against high child mortality or endemic diseases such as sleeping sickness (*trypanosomiasis*), tuberculosis, and leprosy. Consequently, health services remained disproportionately distributed over the country and inaccessible to those in neglected areas – their only contact with public health consisting of the vaccinations intermittently offered by mobile health teams (Eto, 2005; Leh, 1987; Maynard, 2004).[35]

This unequal approach was gradually altered after the Alma Ata conference in 1978, during which the need for ‘health for all by the year 2000’ was expressed.[36] Recognizing health as a human right and a precondition for economic and social development, the conference members stated that primary health care should be accessible – economically, geographically, and culturally – to everybody. Health care should further be explicitly *community based* and *preventive* as well as curative. Cameroon adopted this primary health care approach in 1982.[37] Its major aim was to provide continuous rather than intermittent health services which would be integrated at the village level.[38] However, despite the successes with regard to certain health indicators in the initial years after implementation of the new approach, the economic crisis in Cameroon since the mid-1980s severely disrupted and curtailed many government programs, including those in public health.[39] Numerous problems have since been noted with regard to the execution of the primary health care approach – pertaining not only to the health services, but also to the community level and its interface with health structures.[40]

In order to correct these insufficiencies, the primary health care approach was redefined first in 1985 after the conference of Lusaka[41] and again in 1987 after the Harare conference[42] and the Bamako Initiative, where two major strategies to ‘rationalize’ primary health care were launched: co-financing and co-management. First, a system of cost recovery (*recouvrement des coûts*) was introduced in which patients would be demanded to pay for the health services in order to increase the system’s efficiency.[43] Second, a decentralization of decision-making power into peripheral hands was

proposed, supposedly leading to higher quality of care and greater participation of communities in the (financial and gestational) management of governmental health services. The partnership between local communities and the health care structure would be further reinforced by the instauration of community agents and committees mediating and enhancing dialogue between the two parties (Ministère de la Santé Publique Cameroun, 1993d).

The resulting 'reorientation of primary health care' – formally adopted in 1993 with the 'National Declaration on the Implementation of the Reorientation of Primary Health Care' – entailed a reorganization of both the Ministry of Health[44] and the sanitary map of Cameroon; the health care system was formally reorganized into a pyramidal structure consisting of three major levels: central (national), intermediate (provincial), and peripheral (local health districts, subdivided into geographically demarcated health areas such as the *aire de santé* of Asung).[45] The latter, representing the interface between the local population and governmental services, was supposed to carry out essential health services in a self-sufficient and integrated way, with considerable participation of the inhabitants of the health districts. Offering a 'minimal package of care' – consisting of curative, preventive, and promotional activities – the Integrated Health Centres (*Centres de Santé Intégré*) as they were called, would now only have to refer difficult cases to the provincial or central level.[46]

These elaborate revisions of the health care structure – and the concomitant adoption of several laws to facilitate them – have not led to the envisaged results.[47] Next to the continuation of the afore-mentioned problems, the onset of the economic crisis in the mid-1980s inhibited the process of reformation even more. The Structural Adjustment Programs that were introduced in Cameroon in 1989 in order to develop the national economy and reduce macro-economic inequalities drastically cut public expenditure on health.[48] The admission of Cameroon to the Highly Indebted Poor Countries Initiative in 2000 has made its health policies even more dependent on international conditions and standards. The resulting sector-based approach constantly defined and redefined new strategies for the sectors of health, education, agriculture, and infrastructure in order to make them more operational with regard to human, material, and financial resources. In response, the Ministry of Health developed a National Plan of Sanitary Development (PNDS) for the years 1999-2008, as well as a 2001-2010 Health Sector Strategy, which was again updated in 2006 when problems with meeting the set objectives were anticipated.[49] What Van der Geest already noted in 1982 has become increasingly true for the years thereafter:

> The greatest obstacle lies in the contradictory character of primary health care itself. Its aim is to enable people to become more independent in health matters, but in practice it rather tends to create greater dependency. Where primary health care has produced tangible results it has often done so through 'foreign intervention' (Van der Geest, 1982b, p. 381).

Indeed, where the notions of co-financing and co-management imply contributions from the state, the local population, and international donors, it seems that especially the latter two sources are the most heavily drawn upon. With governmental influence gradually fading away, many non-governmental organizations (NGOs) and private and confessional establishments have come to play a prominent role in the domain of primary health care in Cameroon.[50] The (Catholic and Protestant) confessional sector has – due to its long history in the country – even created its own sanitary map; the Catholics divided the country into autonomous dioceses with an important network of operational sanitary establishments – of which thirty-three can be found in the East Province (Bongoe, 2007) and one in Asung's neighbouring village of Kamandjom. They train health personnel, order drugs, and negotiate with the Ministry of Health. Although drugs at these missionary and other private clinics – even allegedly 'non-commercial' ones – are often relatively expensive, the mere *presence* of medicines as well as the better services lead many people, like the Gbigbil, to resort to these health centres (Kamdoum, 1994b; Médard, 2001; Van der Geest, 1982b).

This amalgam of public, private, national, and international interventions has contributed to an enormous 'balkanization' of the current health situation in the country (Gruenais, 2001; Médard, 2001). Without much coordination, all parties launch different strategies, priorities, and zones of intervention. To this come the many *informal* activities and practices within local medical terrains. With the drastic deterioration of both their own financial situations and public health services, people increasingly resort to 'indigenous' practitioners, self-medication, or the informal drug market.[51] Here, they find counterfeit products – mostly coming from Nigeria and sold in local markets, small shops, or by street vendors '*à la sauvette*' – as well as biomedical medicines from formal institutions, illicitly appropriated and privately sold by health personnel (Eto, 2005; Gruenais, 2001; Kamdoum, 1994b; Kamtcha, 2004; Van der Geest, 1982a).[52]

Thus, as has also been mentioned for several economic terrains in Cameroon, the informal and formal health sectors are dynamically interrelated and mutually constituted (Geschiere & Konings, 1993; Niger-Thomas, 2000). Bernard Hours talks about the existence of a 'sanitary market' which 'stretches from the public dispensary to traditional practitioners, through a private dispensary, several private clinics or maternities, without mentioning the open consultations in the houses in the neighbourhood where 'nurses' practice without certificate, formulating simple diagnostics or serving as therapeutic intermediaries before a more specific remedy' (1985, p. 19, my translation). This sanitary market is constantly adapting to new demands: 'indigenous' healers increasingly use innovative and biomedical symbols in order to advertise a 'veritable African tradition'; Chinese therapies create new hopes and confidence; biomedical staff construct informal offices in their neighbourhoods in order to ensure 'proximity care'; and the unemployed find in the drug business a new way of making their own living, while sick people rely on it for their self-medication (see also Adome, Whyte, & Hardon, 1996; Van der Geest &

Hardon, 1990; Whyte, Van der Geest, & Hardon, 2002). Ironically, this informal health sector seems to attain the goal that remains unachieved by formal public health strategies: namely, to reach and satisfy the needs of the local population.[53]

To conclude, the health situation in Cameroon is extremely dynamic and characterized by internal contradictions. While there has been an increasing focus on *de jure* decentralization and financial autonomy, *de facto* all levels of the health pyramid system are pervaded by centralization, bureaucratization, patrimonialism, and corruption. Rather than the anticipated *de jure* community participation in the 135 health districts and 3,567 public health facilities that currently cover the country,[54] *de facto* people increasingly turn to illicit and cheaper alternatives within this diverse health terrain. This 'profound crisis of the Cameroonian health system', as Médard (2001) has called it, has certainly been exacerbated by the economic adversities since the mid-1980s, but not exclusively so; it also seems a historically situated structural problem. Several ideologies – populist, neo-liberal, religious – have not only tried to tackle these underlying structural predicaments (Gruenais, 2001), but also affected people's perceptions of illness, treatment, as well as their relationship with the state – with the notion of '*état sorcier*' (Hours, 1985) indicating their disillusionment, distrust, and discontent with regard to the current situation. A similar multitude of ideologies, reformations, practices, and perceptions can be found in the terrain of reproductive health in Cameroon, as described in the following section.

Reconnoitring reproductive health

Within the pyramidal health structure outlined above, all three health care levels are supposed to offer reproductive health services; peripheral health centres offer maternal and child care as an integrative part of the 'minimum package of care', specific mother and child care centres in all provinces provide family planning services and aim to reduce maternal and infant mortality, and major cities host clinics for sexually transmitted diseases and high risk pregnancies (Ako et al., 2003). This omnipresence of reproductive health services is, however, largely informed by recently formulated international targets and discourses; the history of Cameroon shows radically different priorities with regard to the reproduction of its population.

As mentioned before, colonists already expressed concerns regarding the low density and uneven distribution of the colony's population. Especially the Eastern Province, in which the Gbigbil were situated, had a very low population count, exacerbated by the high infertility levels in this region. In order to bring economic development ('*mise en valeur*') to this province and the rest of the colony, measures were taken to fight the under-population ('*sous-peuplement*') – seen as the major reason for the under-development ('*sous-développement*') – and multiply the number of African producers. These measures consisted not only of medical interventions trying to

eradicate the spread of epidemics and educating people on hygiene, but also of the distribution of explicitly pronatalist slogans such as 'operation 10 million inhabitants by 1960' (Feldman-Savelsberg, 2002; Geschiere, 1982; Gubry & Wautelet, 1993; Ngo Bell, 1990).

After independence in 1960, this line of thinking continued; a growing population would enhance the economic development and nation building of the country. Where the first five year development plan reiterated the colonial concerns about the unequal distribution and underutilization of the workforce, the third plan ten years later (1971-1975) explicitly mentioned the desirability of demographic growth for productivity and the exploitation of the territory.[55] This growth was encouraged through unequivocal government measures: civil servants with a large family profited from family allowances and tax reduction;[56] parents of twelve children or more were offered special medals for their 'contribution to the nation'; the media and official discourses praised the high proportion of youngsters in the population as the 'spearhead' and 'vital force' of the nation; and any limitation of fertility was legally restricted by a 1969 law prohibiting the sale of contraceptives or any form of anti-conceptional publicity, as well as by penal laws repressing abortion and infanticide (Ako et al., 2003; Ngo Bell, 1990; Tantchou & Wilson, 2000).[57] Cameroon's population expanded; due to a decline in mortality rates – with those for infants dropping from 190/1000 in 1950 to 88/1000 in 1987 – and a rise of the average fertility rate towards more than 6 children per woman, the number of inhabitants almost doubled in 30 years – from 4.5 million in 1950 to 8.5 million in the early 1980s (Bahanag, 2003).

In the meantime, the international community started to worry about enormous population growth in developing countries like Cameroon.[58] Not only was this growing unease inspired by a Malthusian style of thinking – fearing the negative effects of 'overpopulation' on the natural environment – but unrestricted population growth also came to be seen as an impediment to socio-economic development. From the 1974 World Population Conference in Bucharest onwards, explicit recommendations were made to reduce population growth rates in underdeveloped countries. Not surprisingly, Cameroon initially rejected these ideas and propositions. In reaction to the international plea for birth control, the government stated that it would consider family planning only as 'a synonym of birth spacing with the aim to preserve mother and child health' (Ako et al., 2003; Nseke, 2002).[59] The first inclusion and promotion of 'responsible parenthood' in the fifth five year plan (1981-1986) – encouraged by the outcomes of the 1984 population conferences in Arusha and Mexico – was still precarious and sometimes explicitly contested (Bahanag, 2003). Only from the sixth five year plan onwards were demographic variables incorporated into the country's development strategies. Presenting this plan before the National Assembly, President Paul Biya declared:

> I would like at this point to draw the attention of Cameroonians of both sexes to the economic and social consequences of an unplanned increase in the birth rate. Procreation,

> albeit a basic human right, can and must be controlled. The purpose here is not to discard our beliefs, practices and customs in this regard, but rather to increasingly strive for the systematic promotion and institutionalization of planned and responsible parenthood (Commission Nationale de la Population Cameroun, 1993, p. 27).

This change in attitude was accompanied by a relaxation of the law prohibiting the sale and publicity of contraceptives in 1980, [60] as well as the creation of a National Population Commission in 1985 that would assist the Cameroonian government in the definition and orientation of a population policy.[61]

The ensuing 'National Population Policy' was adopted in 1992. It stipulated people's rights to 'freely decide on the number of children they may wish to have' as well as their responsibility to ensure the future welfare of these children.[62] In the same year, with the support of UNFPA, family planning was integrated in existing maternal and child health (MCH) services.[63] The latter, in turn, became an essential element of public health after the 'reorientation of primary health care' one year later.[64] All levels of the pyramidal system were from now on supposed to 'ameliorate and promote the well-being of mother and child in order to reduce the morbidity and mortality rates which remain high in this group' (Commission Nationale de la Population Cameroun, 1993, p. 41). Therefore, contraceptives were included on the national list of essential drugs, policy guidelines were standardized, and training sessions were organized for family planning service deliverers in 1996 – all with the help of UNFPA (Mbuy, 1990; Tantchou & Wilson, 2000; Velghe-Scherpereel & van de Wouwer-Leunda, 1996, p. 116). Furthermore, the Poverty Reduction Strategy to which Cameroon was subjected after its admission to the Highly Indebted Poor Countries Initiative in 2000, was brought in line with the Millennium Development Goals set for 2015 (IMF, 2006, p. 9). The consequential attention to the reduction of maternal and child mortality rates in the country led to the installation of different forms of emergency obstetric care (*soins obstétricaux d'urgence de base* (SOUB), *soins obstétricaux d'urgence complets* (SOUC), and *soins obstétricaux et néo-natals d'urgence* (SONEU)) at the different levels of the health care pyramid.[65]

Despite these formal revisions, the Cameroonian government remains rather reluctant to fully adopt international guidelines with regard to population matters. It took a long time before it finally accepted the 1994 International Conference on Population and Development (ICPD)'s definition of and strategies for *reproductive health* (Tantchou & Wilson, 2000); and it was only in 2001 that it updated the National Population Policy in accordance with growing international attention – and pressure – as well as the changing health situation in Cameroon. Revisions included the broadening of the concept of maternal and child health/family planning (MCH/FP) towards a more inclusive definition of reproductive health covering both men and women in all age groups. Specific attention was now also paid to the HIV/AIDS pandemic that ravages the country.[66] Consequently, two of its major strategic guidelines with regard to health are defined as: 1) the promotion and easing of access to quality reproductive health services, notably for the

mastery of procreation; and 2) the fight against sexually transmissible infections and the HIV/AIDS pandemic.[67] Specific concepts and components of reproductive health care were further elaborated in the same year in a document entitled 'Policy and Norms of Reproductive Health Services'.[68] These components were also formally integrated in the 2001-2010 Health Sector Strategy, which regulated the national health situation at the time of this research; its sub-program on 'health of mother, adolescent, and aged people' aimed to address diverse reproductive health problems for different parts of the population. These were also elaborated in the National Program of Reproductive Health 2005-2010.

With policies becoming more and more inclusive, abortions have increasingly been mentioned as a major reproductive health problem in the country. While the first National Population Policy of 1992 only stated that 'teenage pregnancies, abandoned children and illegal and life-threatening abortions have become ever increasing and severe social problems', nothing tangible was done to tackle the problem – no legal adjustments, no sanitary provisions. In its revised version of 2001, the policy explicitly underscores the need to 'reduce the number of unwanted and early pregnancies as well as provoked abortions caused by adolescents', but again proposes no concrete strategies to attain this goal. An actual implementation of the policy seems hampered by article 337 in the penal law of Cameroon, which almost invariably punishes abortion with imprisonment or heavy fines.[69] The two exceptional circumstances under which abortions can be lawfully performed concern situations in which the pregnancy resulted from convicted rape, or is perceived by at least three professionals to endanger the life of the mother. As most pregnancies do not fit these categories, in practice women can only resort to clandestine and often unsafe means to abort them; they use dangerous methods themselves, seek help from indigenous healers, or illegally undergo dilation and curettage (D&C) procedures after bribing biomedical staff at a considerable cost (see also Nyobia, 2006). Cameroon's restrictive abortion law not only underlies the problem – with 70% of all registered abortions being unsafely induced and contributing to an estimated 20 to 40% of the maternal mortality rate – but also prevents effective implementation of reproductive health measures in this domain. Lately, however, some improvements have been made; the 2001 'Policy and Norms of Reproductive Health Services' now formally includes post-abortion care (PAC) as an essential component of women's reproductive health care.[70]

A more integrative approach to the abortion problem remains complicated, partly due to the constitutive role played by the confessional sector in Cameroon's health care system. Despite their long and active history of providing maternal and child health services, Catholic congregations remain reticent when it comes to family planning and abortion. Most Catholic organizations promote natural means of fertility control through abstinence or calculation of the menstrual cycle; their doctrine opposes all forms of artificial contraception and condemns induced abortions.[71] Protestant churches have

been more liberal in their visions; many Presbyterian hospitals in Cameroon do provide reproductive health and family planning services. Islamic leaders, to the contrary, are noted to occasionally oppose educational programs for youngsters or women's use of contraception (Ngo Bell, 1990; Sala-Diakanda, 2000; Tantchou & Wilson, 2000).

This multiplicity of political, moral, and juridical discourses surrounding reproductive health in Cameroon has resulted in a complex situation in which rhetoric is at odds with the practical circumstances in the country. While the general approach towards population matters turned from explicitly pronatalist to 'supportive to family planning', in practice access to birth control methods remains hampered by legislative as well as practical barriers.[72] While maternal and child health services became an integrative part of primary health care, their practical accessibility and quality remain fairly low (Betbout, Ngueyap, Mudubu, & Rakotondrabe, 2000; MINEPAT, 2008). While the concept of reproductive health was finally included in the revised National Population Policy and numerous health strategies in the country, the latest Demographic and Health Survey of 2004 shows a rise in infant, child, and maternal mortality rates as well as an alarming propagation of the HIV/AIDS pandemic. While post-abortion care is now mentioned as an element of reproductive health services, the underlying dynamics that motivate women to resort to – unsafe – abortion methods in the first place remain ignored. And while different stakeholders share the attention to 'hyperfertility', they tend to forget the high – although drastically reduced – number of women having to deal with infertility and pregnancy interruptions.

With regard to all these matters, circumstances in the East Province are relatively worse than in other parts of the country. Although 131 health facilities are present in the 12 health districts and 93 health areas of the province, different studies have indicated their lack of qualified health personnel, of essential materials and medicines, and of reproductive health services (Délégation Provinciale de la Santé de l'Est, 1989, 1999). While 83% of all health centres in the district of Bertoua (which comprises the health area of Asung) are supposed to offer antenatal care and vaccinations, only 40% of them do actually have a delivery table available, and an even smaller number – 33% – provides family planning services (ibid., pp. 37-38). Consequently, for contraceptive coverage and accessibility, the East is estimated to have the largest 'unmet need' of 7% (MINEPAT, 2008, p. 50), while its HIV prevalence rate of 8.6% ranks among the highest in the country (Mosoko & Affana, 2005, p. 303). Of all pregnant women in this province, 62% have received at least one session of qualified antenatal care, and only 22% of them have delivered in a health centre. In the district of Bertoua these percentages drop to 51% and 5% respectively (Délégation Provinciale de la Santé de l'Est, 1999, pp. 50-52). With regard to infant and child mortality, the province scores worst and second worst with death rates of 111‰ for infants and 187‰ for children (Libite, 2005b, p. 216). And while on a national level 25% of all surveyed sexually active women have indicated to have experienced at least one pregnancy interruption, of which one fifth was induced (Libite,

2005a, p. 73), my data collected in Asung show that even 60% of all surveyed Gbigbil women have encountered at least one pregnancy interruption, of which 11% was stated to be provoked (see Appendix VII).

Clearly, there is a huge gap between Cameroon's policy priorities – reflecting economic dependencies and international power relations – and the actual (reproductive) health situations and stakes in the local terrains. The latter will be further explored in the rest of this dissertation. But before turning to these local dynamics, I will reflect on my own position and research activities in the afore-mentioned uncertain terrains, and outline the difficulties and moral dilemmas these brought along.

Reproductive interruptions researched

The empirical foundation for this dissertation consists of fifteen months of fieldwork in the above described village and its surroundings, divided over three periods between October 2004 and August 2009. While I undertook my first fieldwork trip with the aim of exploring the topic of pregnancy loss in Cameroon for my Master's thesis, I returned for two subsequent, longer, visits to Asung when I was given the opportunity to further unravel the complexities around reproductive interruptions in a Ph.D. researchproject.

During those fifteen months of field research, I worked intensively with about twenty-five women from all age groups, with different educational histories, economic backgrounds, marital statuses, and social positions. Further, there were many male and female neighbours, friends, and children with whom I had informal conversations or interesting casual discussions – all of which were quickly jotted down on the spot or more elaborately written down towards the end of the day. I further interacted with traditional healers and midwives in the village, as well as health personnel and missionaries in both rural and urban areas.

In order to build a relationship of trust between me and my informants, I made extensive use of the anthropological method of participant observation. Especially in the beginning phase of fieldwork, this participation helped me to establish my role as an anthropologist; people came to realize that, even if I resided in the hospital, I was not a doctor. While some old women would lift their skirts to ask for medical help for their problems 'down there' upon our first acquaintance, the villagers soon told each other that I 'just loved to go to the fields and work a bit there' – which, considering the immense distances to their 'terrains' that I voluntarily traversed, they found rather amazing. Participating in women's daily lives entailed not only working in the fields; I also cared for their children, assisted them in the kitchen, shared meals, visited the market and church with them, and spent free time together. Gradually I became involved in diverse reproductive happenings as well. Women invited me to accompany them to prenatal consultations or traditional healers, to attend their deliveries or abortions, or to come and assist the funerals when their babies or children died. Further, I participated in

informative meetings for traditional midwives and mothers organized by PLAN International, and sessions for pregnant women in the village's *Centre de Santé Intégré*.

While this participation in daily life would constantly bring up informal conversations and interesting discussions on different topics, I held more formally organized interviews with the twenty-five women who participated intensively in this study, as well as relevant others such as husbands, family members, missionaries, priests, biomedical staff, and healers. All seventy-seven interviews were conducted in French; only as my knowledge of the Gbigbil language gradually improved, expressions and key notions were increasingly discussed in the local language. Since all my informants spoke French fluently, however, they did not seem hampered by the language to express what they wanted to share with me. Nor did I want to hamper them with pre-formulated questions that would probably reflect more of my underlying assumptions than reveal locally relevant issues. I thus prepared semi-structured interviews that invited informants to elaborate on a set of topics as much as they felt like.

The timing and location of interviews were flexible as well; with the twenty-five female participants, '*les causeries*' mostly took place during a break in the shade after our working day in their fields, or simply in my rooms in the hospital and in the school where I resided during the second and third fieldwork periods. Both locations seemed to work best since they would grant us a moment of rest and intimacy; women would not be called upon by in-laws or children, nor would they feel restrained in saying certain things that were not supposed to be overheard by others.

Photo 2 An informant walking to her field, far away from the village

Most interviews were recorded. Though I initially feared the voice recorder to be an intrusive element, all informants explicitly consented to its application and seemed to get used to its presence over time. Only occasionally, when I remarked a certain hesitancy of an informant to talk about a sensitive topic, I switched the recorder off and tried to make her feel at ease as much as possible. All interviews were transcribed verbatim – a dull work which filled my dark evenings in the village when most people would have gone to

bed, and which helped me to immediately incorporate the gathered knowledge into my subsequent research questions and activities.

Due to the sensitivity of the research topic and the relationship of trust that should necessarily be created before being able to speak confidentially about it, I usually discussed rather general themes in the first interviews. These entailed, for example, notions of pregnancy and embryology, the aetiology of pregnancy interruptions, healing methods, values of children, kinship and marriage arrangements, witchcraft stories, or oral histories of the village. These thematic discussions provided me with contextual insights that would prove indispensable to understanding the life stories women would share with me at a later point.

This contextual knowledge was further deepened through twelve focus group discussions. Just like the afore-mentioned interviews, these centred upon different themes. Every theme was discussed twice: first with a group of older women and then with a group of younger women. This age-based division was made on purpose; I hoped to avoid situations in which certain opinions or experiences – especially those of younger women – would not be expressed or would be repressed due to generational differences and power relations within the group. One group discussion focused on the aetiology of pregnancy interruptions and asked for feedback on, and a severity ranking of, the different aetiological notions I had identified earlier in the study.[73] Subsequently, women were asked to discuss these notions in relation to four different *vignettes* (see also Whittaker, 2002) presenting hypothetical stories of pregnancy interruption (see Appendix II for a description of the vignettes). *Vignettes* were also used to discuss womanhood, sexuality, and maternity during another focus group discussion (see Appendix III). A third gathering was organized to reflect on the different stages of a hypothetical life course, discussing the changing importance of children and relationships over a life-time (see Appendix IV). In what turned out to be another hilarious and animated meeting, women were asked to comment upon a hypothetical abortion story in theatrical 'public judgments' while playing out different kinship roles (see Appendix V). A final focus group discussion with younger and older women focused on questions of suffering and agency. Other discussions were held with groups of men and traditional midwives, on reproduction and care respectively.

Although the organization of the focus groups required flexibility – with some people coming too late, not showing up at all, or suddenly walking away during the discussion – all gatherings in the end contained six to ten participants. The living room of my residence at the time was very suitable for the occasion; since it served as a classroom it offered us chairs, tables, and a blackboard, as well as an environment of privacy and confidentiality. The discussions – lasting two or three hours – generated important insights that, due to the specific dynamics of focus groups, could not have been obtained otherwise (see further Carey, 1994; Kitzinger, 1994; D. L. Morgan, 1996). Discussions on hypothetical case studies turned out to be especially animated and heated – which gave

me, besides some frustration at moments of almost impossible transcription, dense information about shared *and* contested reproductive knowledge and norms.

These thematic interviews and focus group discussions served as an excellent background to comprehend and contextualize the lived experiences of reproductive interruptions, as recounted to me in the life stories of thirteen informants. The ninety-four biographical narrative interviews I held with them were, in contrast to the semi-structured thematic interviews, only 'lightly structured' in-depth interviews (Wengraf, 2001). I would start from a single initial narrative question and allow narrations of the informant in any thematic or temporal order. Only later would I occasionally intervene with some clarifying and narrative-eliciting questions.[74] The collected stories are diverse; their variety encompasses not only the different backgrounds of the women – young and old, unmarried and married, uneducated and educated, with rural and urban pathways and projects – but also the diverse reproductive events they recount – covering primary and secondary infertility, interruptions during various stages of pregnancy and in the neonatal period, as well as successful and unsuccessful abortion attempts. The openness of the method further allowed for the emergence and discussion of many other, often unexpected, themes. While several of these issues had already been discussed separately in the foregoing thematically organized interviews, the life stories now showed their interrelationships, their specific manifestations within reproductive conjunctures, as well as the relative importance and meanings attached to them by the informant – at different moments in life, as well as in different moments of storytelling. Indeed, the sequentiality and intensity of the biographic narrative method – consisting of at least three in-depth interviews with each informant – allowed for recognition of both the dynamics of women's reproductive experiences during their lives, and the dynamics of their narration and the shifting interpretations of these events during the interview.

This touches upon two issues. First, following Rosenthal's (2004, 2006) distinction between *narrated* life (the life story) and *lived-through* life (the life history), we should be aware that the stories my informants told me were constructions and interpretations of their past reproductive experiences. These constructions and interpretations are informed by past happenings as much as by present situations (position and stakes) and future ambitions – and are thus constantly changing.[75] Second, *what* is told and *how* things are told also depends on the specific context of the biographical narrative interview. Although I tried to keep my intervention as minimal and non-suggestive as possible, the direction the informant would take and the topics she would discuss would be constantly constituted and reconstituted in interaction with myself. As Michael Jackson (1998, p. 23) has noted:

> Life stories emerge in the course of *inter*subjective life, and intersubjectivity is a site of conflicting wills and intentions. Accordingly, the life stories that individuals bring to a relationship are metamorphosed in the course of that relationship. They are thus, in a very real sense, authored not by autonomous subjects but by the dynamics of intersubjectivity, in which initiatives are often frustrated and desire transformed. Yet unlike material objects,

> which are also produced in the course of human interaction, stories always convey this twofold sense of the human subject as *both* actor *and* sufferer.

Building on this insight about the (intersubjective) construction of *past* reproductive experiences in biographic narrative interviews, I tried to get a better sense of the *actual* happenings around fertility interruptions by proposing to two women who experienced a miscarriage during my fieldwork periods to report on their experiences, thoughts, and feelings in a diary. However, as mentioned for the case of Celestine in the prologue to this thesis, this method did not work out as I had expected. Keeping a diary just did not seem appropriate in these women's daily life realities – where pregnancy interruptions remain first of all discretely hidden; where oral expressions are largely preferred over written ones; and where people are not acquainted with notions of privacy, inner feelings, and daily punctuality which underlie the practice of diary-keeping.

While diaries did not appeal to women, other rapid appraisal techniques were much appreciated – and proved to be insightful social events as well. I used the methods of free listing and pile sorting in order to unravel the aetiology of pregnancy loss. In the free listing method, I asked women to cite all the causes of interrupted fertility that they could think of. Subsequently, I noted down all the seventy-four gathered terms on separate cards, and asked women to sort these into coherent piles. They could make as many piles as they wished, putting those cards in the same pile that they considered most alike or belonging together. These methods demonstrated the complexity of local aetiological classifications and proved useful for relating aetiology to health-seeking behaviour. Further, the process of sorting cards in itself revealed much about the generation, negotiation, and contestation of aetiological knowledge – which proved almost as insightful as the specific clustering of cards that would eventually result. While I would always approach one single woman with the bulk of cards, a group of children and elders would soon surround her and publicly contest or suggest which cards belonged to which pile.

Another rapid appraisal technique evolved in reaction to an apparent need that I had witnessed. While not fond of writing, women often *did* like to draw with a small piece of bamboo in the reddish sand to visualize their ideas – in cases where French words lacked or were unknown to them. Having noticed this tendency to draw when speaking about embryology, I decided to use the body mapping method (see also Mitchell, 2006; Nahar, 2007; Zaman & Chowdury, 1998). Eight women were given three white papers presenting only the contours of a human body. I asked them to draw into these 'transparent bodies' the pregnancies of one, three, and seven months of gestation respectively. During a subsequent fieldwork period, they were also asked to draw all reproductive organs and body parts they deemed necessary to conceive and give birth (see some results on pages 66-73 in Chapter 2). This method proved very insightful; it allowed women a space to convey their interpretations of 'normal' reproductive functions and pregnancy developments – and, by implication, those of pregnancy

interruptions - in their own words and images. As Scheper-Hughes and Lock (1987, p. 18) have noted, 'ethnoanatomical perceptions, including body image, offer a rich source of data both on the social and cultural meanings of being human and on the various threats to health, well-being, and social integration that humans are believed to experience'. The method thus proved highly relevant in this study that postulates a specific attention to pregnant bodies and their social meanings. That these meanings are constantly contested was revealed by the way in which drawings were developed and commented upon by others; like with the pile sorting activities, this process illuminated the multiplicity of interpretations as well as their relative importance.

Photo 3 Body mapping session with an informant

Finally, I conducted a demographic survey in order to have an idea of wider reproductive patterns and health situations in the village – where no detailed registers or demographic sources were present. Every woman of twelve years or older who was (or had been) sexually active was interrogated about her family situation, her matrimonial situation, and her reproductive history. As reaching the 290 women in the village and speaking privately and intensively with them was time-consuming, I was assisted by the *présidente* of a women's association in the village, who had by then already become my 'adoptive' mother (see also Chapter 5). In a sense, the survey was 'anthropological' in character; conducted only towards the end of the research period, it incorporated local concepts and notions that had proved relevant during earlier fieldwork. The formulated questions aimed to connect to people's perceptions and lived realities as much as possible (see Appendix VI for the questionnaire).

However, some concepts or hidden assumptions were questioned or contested by the respondents. Difficulties would already arise with the very first questions concerning age and marital status. While the first issue was often simply unknown, the latter yielded many ambiguous answers; which marital status should be assigned to, for instance, young women who were engaged in informal sexual relationships that could possibly, but not necessarily, lead to a more stable relationship, older women who had just left their

marriage and lived with their own family again, or those whose husband had died and who were currently living with their brother-in-law? Women's own definitions of 'engaged', 'married', and 'divorced' varied and seemed flexibly employed. My anticipated alternative to ask women whether several parts of the bride-price – *kanako, monni niaŋa bon, ivoula* – had been transferred, was somehow helpful to overcome these difficulties and to specify the labels 'engaged' or 'married'. Still, it could not totally incorporate the flexibility of local conjugal relationships; what if a woman had had several marriages in which different transactions had been completed by, and children had been borne for, different husbands?

Notions of child births and losses revealed a similar blurriness. Despite my efforts to explicitly define 'live births' and 'wasted pregnancies' before asking questions, women would mention stillbirths in the category of 'live births' or report neonatal deaths as 'wasted pregnancies'. Quite often the total number of pregnancies that a woman initially mentioned would not correspond with the sum of 'live births' and 'wasted pregnancies' indicated at a later stage. Sometimes dead babies had been forgotten; sometimes wasted pregnancies had initially not been counted. Further, several women would report a certain number of children while others told me they had been infertile all their lives. Others would denote their 'wasted pregnancy' as a spontaneous abortion while outsiders whispered to me that it had been provoked. With regard to questions about induced abortions, I traced some hesitancy, especially in very young women. They would laugh shyly at my question of whether they knew some friends or neighbours who had induced an abortion, and then timidly answered that they did not; some would be hesitant to share knowledge of abortion methods with me until I had given various local examples myself.

My display of local knowledge – not only concerning abortion procedures, but also with regard to marriage dynamics and fertility notions – seemingly encouraged women to share intimate knowledge with me, or even to consult me in case they dealt with unwanted '*retards*' or a wish for contraception. In the end, despite the conceptual flaws, the indeterminate answers, and the occasional shyness or unwillingness to talk, this survey offered me many new insights (see Appendix VII for the quantitative results) *and* new informants – with those women willing to elaborate on their reproductive trajectories becoming more intensively involved in my research. The mutual interplay of qualitative knowledge and quantitative data gathering – a methodological mix lending itself to grounded theory in fertility research (Sporton, 1999) – thus proved a valuable way of exploring both patterns and subtleties of fertility behaviour.

In all this, the display of competence in the local Gbigbil language also played an important role; the more I seemed interested in, and able to understand, their vocabulary, the more women were eager to elaborate upon local concepts or involve me in intimate discussions in their own language. It was far from easy to arrive at the point where I could roughly understand conversations and where the villagers celebrated my

Gbibgil language skills – which proved my identity as a 'real' daughter of Asung. As the language had never been officially documented, I had to create my own Dutch-Gbigbil dictionary, as it were, with inventive phonetic transcriptions for unfamiliar sounds and tentative guesses of possible grammatical rules. My interaction with linguists and study of documented sources at the Summer Institute of Linguistics (SIL) in Yaoundé provided me, to my relief, with some clues about proper transcription methods as well as general linguistic patterns in the East Province.

The empirical methods were complemented with archival research. Before entering the field, I had already searched the archives of the Congregation of the Fathers of the Holy Ghost ('*Paters van de Heilige Geest*') in Gemert, the Netherlands, because these Fathers were among the first to enter the East Province of Cameroon and had widely documented (and often also criticized) the local habits they had encountered there. In Cameroon, I visited the National Archives, the Ministry of Scientific Research and Innovation, and the Ministry of Public Health, as well as several research institutes (notably the *Institut de Formation et de Recherche Démographiques* [IFORD], the *Institut pour la Recherche, le développement Socio-économique et la Communication* [IRESCO], and the *Institut de Recherche pour le Développement* [IRD]).

For statistical health data about the East Province, I contacted the Provincial Delegation of the Ministry of Public Health, the Association for Traditional Healers in Cameroon, and PLAN International, the only active NGO in the village of Asung. Other NGOs active in the domain of reproductive health were visited in order to explore their aims and contributions to (inter)national reproductive health objectives. In Yaoundé I contacted the United Nations Population Fund (UNFPA), the Cameroon National Association for Family Welfare (CAMNAFAW), *Femmes-Santé-Développement en Afrique Sub-Saharienne* (FESADE), and the *Association de Femmes Volontaires pour le Développement* (AFVD), while in Bertoua I talked with representatives of the *Association d'Assistance et de Développement* (ASAD) and the *Centre de la Promotion de la Femme et la Famille* (CPFF).

Further, I visited the court in Bertoua to inquire about the number of cases concerning induced abortion, but tellingly no convicted cases could be found at all in the – rather incomplete and disarrayed – registers. Problems with registers also emerged in the health centres and hospitals I visited in Asung and its surroundings (the village's *Centre de Santé Intégré*, the *Centre Medical d'Arrondissement* in Bélabo, and the *Hôpital Provincial* in Bertoua). Complete periods of weeks or months were missing, prenatal consultations were badly registered, accounts of deliveries seldom recorded, and cases of pregnancy interruption were sparsely and inconsistently mentioned. Once more, I was confronted with the effects of uncertain livelihoods and rapid changes in infrastructure. In the next section, I will expand on my own experiences of being '*sur le terrain*' and sharing the experiences and insecurities of my informants.

Moral matters

The three fieldwork periods in which the fifteen months of research were subdivided were quite different in character. While I had entered the village as a twenty year old student hardly managing to speak proper French, and living alone in the village dispensary where the three men in the beginning of this chapter introduced me, I left five years later as a 'daughter of the village' informally adopted by a local family (thus carrying the name of '*ngon Bibakung*'), knowing almost every inhabitant of the village, having acquired a typical *camfrançais* accent, and even managing to speak some Gbigbil. As much as older *mamas* often commented how I had developed from a 'little child' ('*mon mongo*') into a 'woman' ('*munka*'), my younger informants told me how I had turned from a 'student' ('*mon sukulu*') into their friend ('*abo*') and even accomplice ('*ma complice*') in secret affairs. Both I and my relationship with the people had changed. The more I became acquainted with culturally appropriate expressions and behaviour, the more people seemed at ease to share their thoughts and experiences with me. More and more, a certain level of intersubjectivity (M. Jackson, 1998; A. Turner, 2000) could be attained during random meetings at the market, at moments of tiredness after working in the fields, while grieving together for beloved ones, in informal conversations while preparing and eating dinner, or during intensive interviews on my bed.

At the same time, my outsider position allowed me to make mistakes, pose inappropriate questions, or make the unsaid said – moments that were hilarious or, with hindsight, shameful but taught me a great deal about the norms and praxis of social relationships in the village. Not only my behaviour, but also my personal characteristics would set me apart and influence the interactions performed and relationships built. Being a white, well-to-do, educated, unmarried, healthy, and young non-mother certainly affected the answers people would give to my – odd – questions on fertility, pregnancy, motherhood, and reproductive interruptions. While my ignorance as an outsider and as a young woman inexperienced with reproductive matters would sometimes help me in opening doors to some fields of knowledge, there were certainly also doors to other fields of expertise that I – just as many other young women or non-mothers in the village – could not enter.

In return, my outsider status also created expectations with regard to my *own* fields of knowledge and expertise to be shared with informants – expectations that I could not always meet, unfortunately. My incompetence in biomedicine was most regretted in this respect. It was not only unexpected and at times disbelieved by the villagers, but it also proved of practical disadvantage at critical moments when medical interventions were either demanded from me (in the village), or performed (in the hospital) without me being allowed to attend. Such situations in which my limited knowledge and capacity to act and meet the demands of my informants surfaced, raised ethical concerns about the degree to which I was *entitled* or even *able* to intervene in the lives of those who shared their suffering with me – with or without hope for help. Despite

these ambiguities around my own role, I also felt how being simultaneously an insider and an outsider *could* be helpful in the lives of my informants; it made me an appreciated conversation partner for those who wanted to share their worries and secrets with somebody. While I would listen to their situated stories, my 'unsituatedness' in the village made me a neutral party who had no stake in revealing their secrets and who would moreover leave the field – and take the secrets along.

The secrecy and ambiguity that surrounds my research topic heavily influenced my positioning in the field. I had to be extremely cautious in framing my research interests to strangers, in posing questions about taboo topics during initial interviews, in relating my informants' experiences to others when asked to, and in offering help and showing interest in actual abortion practices. A careful balance was continuously needed: I wanted to be accessible and approachable for secret matters, yet too obvious an interest in, and association with, induced abortions could possibly impair an initial relation of trust or make women unwilling to publicly associate with me – fearing that others would suspect her to be involved in abortion matters. I became highly aware of my own words, deeds, and position, and came to experience – like my informants – what it is to live with (reproductive) secrets while subjected to social control and surrounded by gossip networks.

While growing closer to the villagers, I became more involved in the whims and woes of their daily lives. Not only were these (secretly) shared with me in personal stories and worries, but I also participated in minor and major life events. Happenings in which I shared, and personally experienced, daily life uncertainties ranged from the very trivial to crucial moments of life and death. I felt the disappointment when we were waiting in vain for government officials who had promised to bring some gifts, or when *bayams* from other parts of the country – crucial for the success of the village market – failed to show up in economically restrained periods. I followed how witchcraft accusations suddenly emerged and rapidly developed after unexpected events. I had to deal with sudden illnesses of myself and my informants, or their hasty departure to family members facing misfortune elsewhere. I shared the uncertainty surrounding missed periods and was involved in abortion practices. I witnessed several children being born, I saw beloved ones die. In a drastic way, I came to experience the vulnerability of human life and social connections. Local ethics and existential attitudes were made clear to me in ways that became even more radical when they clashed with my own moral convictions.

Introspection was indispensable to make sense of all these happenings. It allowed me to reflect on ethical questions of guilt, complicity, moral responsibility, injustice, vulnerability, and powerlessness, which accompanied many of my personal experiences and emotions. It also helped me to situate the stories and actions of my informants within this unstable 'terrain'. I tried to create an awareness of how the former might impact on the latter and vice versa – and how these interfaces might have influenced the course of my research. In my interaction with others, I tried to cling to the principle of 'doing no

harm'. However, this question turned out to be a complicated one in cases where foetuses were aborted, where the physical well-being of my informants had to be compromised in order to fulfil their wishes, or where not only my informants but also their social relationships were implicated in certain fertility-related matters. Given that my own actions and decisions were, as much as those of my informants, undeniably part of my improvised 'subjunctivity' and 'judicious opportunism', I can never be entirely sure whether they were the most appropriate or morally satisfying for all stakeholders involved. Yet, what I can be sure of is that my personal commitment and concern with the stakes and sorrows of my informants, as well as my critical reflections thereupon, were essential to write this dissertation in both an empathic and an analytical way.

2. EATING BANANAS AND FILLING WITH FORCE: ON PREGNANCY DEVELOPMENT AND MANAGEMENT

Diana is sitting in her kitchen, waiting for the cassava to cook in the pot on the fire. While I am playing with her 7 month old daughter Joëlle on my lap, Diana starts moving uneasily on the bamboo bed opposite to me. Hesitantly she tells me there is something she would like to ask. 'I have been waiting for my period for a few days now. Normally I start bleeding every thirteenth of the month, but this month I didn't see anything. How is this possible? Do you think I am pregnant?' Somewhat bedazzled I inquire about her menstrual cycle during her current breastfeeding period and she tells me that the principle of 'not menstruating while nursing' does not apply to her. Smiling shyly and bending her head, she also adds that the local norm of abstaining from sexual intercourse during this period does not work for her and her husband Baudouin. Although they try to avoid intercourse during her fertile days, Diana reflects, 'It could be this kind of accident of which people say: "You don't enter a car because you are afraid of accidents, but when you start walking, you slip and sprain your ankle!" You see how accidents happen, Erica? You try to avoid them, but there is always a risk'. Together we conclude that she also risks being pregnant now.

I ask her if she has already discussed the matter with Baudouin. Diana tells me, 'My husband wants children and he is very proud to know that I missed my period. He wants a boy as soon as possible. But I think it is far too early to get pregnant again. Joëlle is only seven months old. She doesn't eat properly yet and depends on my breast. If I would get pregnant now, this would spoil my milk and she could even die![1] No, Joëlle should first reach fifteen months before a new pregnancy enters. A gap of two years between two children is good. Both will survive. And people would also soon detect my pregnancy because of the vomiting, the changing skin colour, and the craving for food. My mother-in-law will surely notice and start to gossip. Imagine how people will make fun of me when they see me walking through the village with a big belly in front and little Joëlle attached to my back! Oh, I don't sleep anymore or I dream that I see my period. Sometimes I just wear sanitary towels in my underwear, hoping that some blood stains will appear on it, but I don't see anything. If this is a pregnancy, I don't know what to do. I will search for remedies that will evacuate the blood that is now obstructed by the pregnancy. But I am also very afraid. Last time I tried to remove my pregnancy with a needle, the foetus only came out after four months and I nearly died. It was very dangerous. So I will wait for a few more days, but then it is important to act as quickly as possible'.

Five days later we meet again and discuss the matter at hand. Visibly troubled, Diana informs me that there is still no sign of a period. When I ask her what the next step will be, she says, 'I would like to go to the pharmacist of the hospital. I saw him this week and begged him to help me. Initially he refused, but then I begged and asked him to consider my position and the age of my baby. I asked him to pity me. What can I do without any means? He finally proposed me to buy some Nivaquine

pills.[2] *He has them at home, so I can come and take them there, secretly. Nobody will know. Since these pills are often prohibited to pregnant women, the pregnancy will surely leave if I take them now. If only I would have known that it could be so simple, I would have done it the previous time as well. I would not have needed to insert this syringe and risk my life! This time it will happen quickly. He said twenty pills will be enough. I will have to take four pills a day, so after five days it will be over. Oh Erica, just pray for me that the thing that we talked about doesn't stay and that it will quickly leave. I will let you know as soon as I see the blood'. And so it happens. When I meet Diana a few days later on the market, she grabs my hand and whispers, 'It has come'. Visibly relieved and happy, she thanks me for my help and advice. 'My worries are over; I will just take good care of Joëlle now'.*

Vividly remembering this happy ending of a worrisome period, I am rather surprised when Diana tells me one month later that she really regrets having taken these pills. Probed to elaborate further, she says, 'In the end, it was not even a pregnancy. One can never know, but I am quite sure it was only a troubled period. After all, my husband and I had constantly avoided a pregnancy. We accurately counted my cycle and it was almost impossible I would conceive. It is only this time that I think it might be a real pregnancy now. Although I talked a lot to my husband, he did not want to listen to me'. Even more confused I ask her if she means that she again missed her period this month. She relates how Baudouin had forced her to have intercourse during her fertile days and that she will have to wait and see if she will menstruate later. She does not. Without telling her husband, she buys some Nivaquine pills, which again prove effective. In the months that follow, Diana keeps on sharing her insecurities with me every time her period is due. When I leave the field, Joëlle's first birthday has just passed. I ask Diana what would happen if she were to get pregnant after my departure. Smilingly shrugging her shoulders she says, 'It is God who sends children. I would not refuse it. Joëlle is old enough to allow my belly to grow. And if I bear another girl, I will give her your name'. [3]

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This chapter opens with a story about the very start of a pregnancy: its conceptualization as such. Before we can try to understand what it is to want, keep, lose, or interrupt a pregnancy for Gbigbil women, it is important to know what a pregnancy *is* for them. That this question cannot be unambiguously answered is shown by Diana's story; especially the initial phase of a potential pregnancy is pervaded by uncertain stakes and negotiable definitions. Diana constantly defines and redefines her notions of menstruation, missed period, 'troubled' period, and pregnancy – as well as the desirability of each of these events at specific moments. In the following, I will further explore the ideas that exist in Asung village with regard to reproductive processes before, during, and after the onset of pregnancy; Diana's story will be situated within existing constructs of fertility, menstruation, conception, embryology, and delivery. These will form the basis from which to proceed to the ideas and decisions around reproductive interruptions in the following chapters. For, as Sargent (1982, p. 35) has noted, 'An understanding of these processes (…) is pertinent because of the role which ideal constructs regarding

reproduction play both in influencing and justifying choices which arise in relation to various reproductive processes and associated events'.

Yet, the current chapter does more than only describing 'ideal constructs'; it aims to situate these reproductive conceptions within Asung's social and medical terrains, as described in the previous chapter. It explores how women deal with the uncertainty and contingency of reproductive processes in their everyday lives, and shows how they constantly oscillate between material and social, predestined and actual, and 'indigenous' and biomedical realms. In many ways, women tactically manoeuvre the insecurities that pervade pregnancy developments – from the very onset as faced by Diana, to the moment a newborn baby expels its first cry of life. These manoeuvres set the tone for what will be discussed in the chapters to follow: women's navigations of reproductive happenings which are *not* in line with the expectations exposed in this chapter.

Female physiology and fertility: divine destinies to be directed

Though Diana repeatedly wished to evacuate what would probably become a pregnancy, at the same time she assured me that she did not refuse the children God would send to her. When talking about her future ambitions, she expressed the desire to eternalize in Baudouin's household and bear as many children as possible, even ten – if God would allow her to. Indeed, no pregnancy (*abum;* also the word for belly) can 'enter' without divine approval; in the end, it is God (*Zambe*) who decides to send a child to a woman or not, whatever her own childbearing intentions and practices at that moment.[4] *'L'homme propose, Dieu dispose'* ('Man proposes, God disposes') is an expression that women often invoke in this respect. Fertility is ultimately Godly endowed; God gives women their reproductive organs and blesses them (or not) with 'the blood for childbearing'. Thus, every woman is thought to have a predestined number of children (*mizəng mibon*) on her 'cords of children' (*mikol mibon*) in the womb (*kombe*), waiting for God to decide when and to what extent they will develop. These 'cords of children', also mentioned by the neighbouring Beti in South Cameroon (Laburthe-Tolra, 1985) and by women in Gambia (Bledsoe, 2002), repeatedly appeared in my informants' drawings of the female reproductive system.[5]

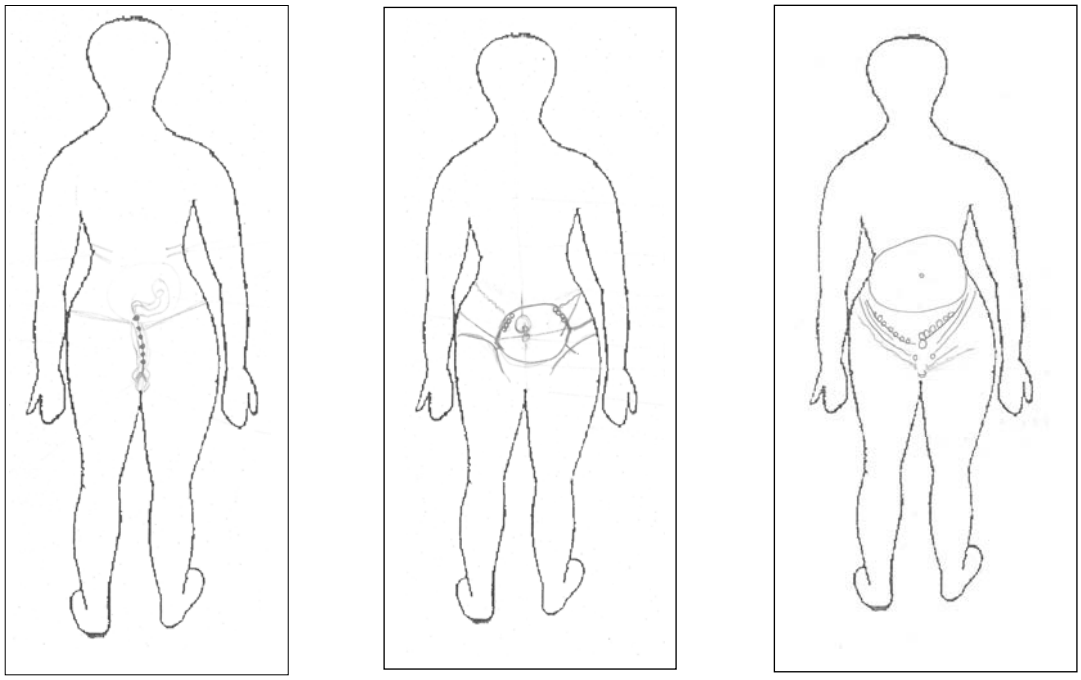

Figure 3 Body maps of the female reproductive system, showing 'cords of children'

The cords of children – here portrayed vertically, circularly, or horizontally – were often drawn as, and compared to, chains. Indeed, the word *zəng* denominating the children (*bon*) who await their maturation on the cords is also used for the beads of a necklace. Others equate the Gbigbil word for cords (*mikol*) with the French word for fallopian tubes (*trompes*), while leaving its function as residence for children-to-be unaltered. Although all women are believed to be endowed with such cords – or fallopian tubes, for that matter – not everybody is lucky to have 'the blood for childbearing'. Some might end up permanently infertile, while others are only intermittently sent children by God – an affliction called *abial kok,* or 'the childbirth of a giraffe'. To thus locate one's reproductive capacities within the natural (blood) or supernatural (God) realm is to portray fertility as an unalterable affair; what resonates through these depictions is the inherent uncertainty and unpredictability of reproduction – not only its endowment, but also its onset, its development, and its outcomes.

Although God's plans can never be known by human beings, there are several ways in which women's destinies can be (temporarily) revealed. In cases of infertility or *abial kok,* women can consult diviners for confirmation of whether they (still) 'have children in the belly' or not. Such healers may even reveal the conditions under which these children can come into development. Likewise, I heard several accounts of dreams (*dəm*) in which dead relatives predict fertility outcomes and announce ways to achieve them. This happened to mama Stéphanie, whose dead father had proclaimed in a dream that she would first bear two girls out of wedlock and give them to her own family – which, ultimately, she did. It also happened to mama Rosie's paternal aunt, who was told

by her dead father to rub saliva on the belly of her brother's wife (mama Rosie's mother), which would result in a pregnancy of a girl to whom she was to give her own name: Rosie. The realizations of these dreams show again how the fertility of Gbigbil women is perceived to be predestined and subjected to both divine and ancestral approval – something which has also been reported for other ethnic groups in Cameroon (Aboubakar, 2008, p. 42; Beninguissé, 2003).

This does not mean, however, that such ideas of ultimate endowment and approval render women fatalistic or passive carriers of their pregnancies. To the contrary; almost paradoxically, women may invoke exactly this idea of predestination to justify their fertility regulation and management practices. Especially when they have already borne at least one child, this proof of 'having children in the belly' gives them considerable room to manoeuvre. Not coincidentally, it was my informant Dorine – a 19 year old mother of one 4 year old daughter, longing to postpone childbearing – who told me:

> Some women have small lines [striae] on their belly or on their breasts. It appears when you are pregnant. Look here, I have it on my breast as well [she uncovers her right breast and shows it to me]. I don't have it on my belly, because when I had given birth, my mother took a banana peel and rubbed it on my stomach. So it didn't appear there. But if you have it, it is also our tradition; we know that you will bear a lot of children. You have children in your belly. We call them 'the lines of children'. Every woman you see with these lines will give birth whatever happens, even if it takes a hundred years!

Dorine's visual proof and expressed conviction of her endowment of fertility seem to appease the clash between the pressure of her in-laws to bear another child and her own refusal to do so. Since she has already shown that God has given her 'the blood of childbearing', she claims to feel 'no need to rush'. The idea of predestination does not inhibit women from exerting certain kinds of agency in their daily reproductive lives; it often *supports* them in doing so. The idea that God provides and decides might make reproduction uncertain, but it can also give women a tool to deal with this uncertainty.

One concrete manifestation of God's fertility endowment that forms a tool for reproductive management is menstruation. Asked about the reason for menstruation, all informants invariably answered that it was God who decided that women should menstruate in order to bear children. The answer given by Diana is typical in this respect:

> A woman menstruates because it's God who made us like that. Our belly is open. A flow of blood is needed to be able to conceive. If you don't menstruate, you cannot get pregnant.

The openness and flow that Diana mentions dominate women's physiological explanations of menstruation. With the onset of menstruation, a girl's body turns from a dry state into a wet, mature condition. Women's mature bodies are regulated by a normal flow of blood, which can become blocked by conception; in fact, every menstruation is considered a missed chance for a pregnancy.[6] If no conception has occurred, the body

will open itself at the moment of menstruation and evacuate the blood, as well as the sperm of last month's intercourses that have not resulted in a pregnancy. Menstruation is therefore, apart from a marker of womanhood and possible motherhood, considered a regulatory mechanism of the body, which 'removes all the dirt' and keeps the female body healthy.

Though women believe that the regulatory flow is a natural process created by God, they might give it a helping hand. From time to time, they 'wash the stomach' (*isŏ abum*) by drinking or vaginally administering herbal remedies, or by resorting to biomedical injections or dilation and curettage (D&C) services (see also Eschlimann, 1982; Koster, 2003; Nations, Misago, Fonseca, Correia, & Campbell, 1997; Newman, 1985; Renne, 1996; Van de Walle & Renne, 2001). As such, they aim to remove the extra 'dirt' (*bīt inu abum*) that accumulates over time, to prevent the blockage of fallopian tubes, to regain regularity of menses, or to encourage conception in a clean and healthy body. Other interventions aim to regulate the workings of the 'women's worm' (*song bunka*), believed to wander around in the belly and cause (pre-)menstrual pains by picking with its teeth. In normal conditions, this worm is supposed to open its mouth once a month around the same date, after which blood is released and menstruation induced. Daniëlle explains:

> There are different sorts of worms. There is the bad worm that causes miscarriage, but there is also the 'worm of childbirth'. That's uniquely for your menstruation. When you are about to see your period, it will pick you in the lower abdomen. As soon as you have your menstruation, it stops and does not hurt anymore. If you would get pregnant then, you wouldn't even have problems. It doesn't evacuate your pregnancy. It's not too bad to have this kind of worm. It's even normal.

The workings of the women's worm become *abnormal*, however, when blood is abundant, thick, darkly coloured, or accompanied by a lot of pain (*isōki*). Here, the bad form of the women's worm is suspected to be at work; the condition becomes pathologized. The extreme pain it causes in the lower abdomen is said to make women scream out loud before and during menstruation – something that is highly unusual in a setting where women are not supposed to publicly express their pain. Human intervention in these so-called 'troubled' or 'painful' periods is deemed indispensable and can only take place 'indigenously' (*à l'indigène*) with local herbs, since treatment at the hospital is thought to aggravate the situation.[7] This condition affects many women during their reproductive trajectories; almost half of all participants (47.9%) in my demographic survey indicated having suffered from this worm at least once in their lives (see Beninguissé, 2003, for ideas on 'vers de femmes' elsewhere in Cameroon, and Appendix VII for the survey statistics).[8]

Despite the perception that menstruation is a natural process created by God, Gbigbil women thus constantly observe, evaluate, and regulate the frequency, colour, smell, thickness, volume, or pain level of their periods. Most menstrual regulation

practices serve yet another goal: the evacuation of 'what could become a pregnancy'. 'Washing the stomach' then becomes a means to prevent the 'crossing' of sperm and blood, and thus the eventual formation of a pregnancy. The following section will illustrate how such post-conceptional inducements are supported by embryological notions that show only a gradual development of a pregnancy – thus creating a yet undecided initial state that can be explicitly directed.

Filling with force: expected embryology

At the end of menstruation, a small amount of blood is believed to stay behind in the woman's vagina and 'wait for the pregnancy'. It is at this point that conception is perceived most likely to occur; since the female body is still in an open state, it is very receptive to men's semen (*medom*). However, this does not *always* or *automatically* mean that pregnancy results if semen enters at this moment. Although bodily conditions are most favourable to conception now, its actual happening remains uncertain and ultimately dependent upon God's will, as Dorine explains:

> After sexual intercourse, the sperm might transform itself. If you have the chance that God says, 'As soon as the sperm enters, it will form a child', you will get pregnant. And if God wants you to be infertile, you can make love as much as you want, but you won't bear a child. The sperm enters, but it will be evacuated by your menstrual blood and vaginal secretions.

However, when all conditions – both physical and metaphysical – are favourable to conception, the opening in the woman's body will close as soon as the semen has passed it. The flow of menstrual blood is now blocked and will mix with the semen in order to gradually 'form a pregnancy' ('*ayadīm abum*'). Similar perceptions have been described for different ethnic groups in Cameroon (Aboubakar, 2008, p. 42; Beninguissé, 2003; Copet-Rougier, 1985). My informants believe this mixing to be one between two sources of *blood*: the blood of the woman and the blood of the man – whose sperm is considered to be a transformation of his blood. Here a third condition – next to metaphysical accordance and physical susceptibility – comes into play to ensure a successful conception: the compatibility of the man's and the woman's blood (see also de Lesdain, 1998). These are conceptualized as groups A, B, and C or as having different 'strengths'. The blood of men, youngsters, and Africans is stronger than the blood of women, the elderly, or white people. Problems in conception are believed to occur when the strengths are too disparate or blood groups dissimilar.

Only the mixture of two *compatible* bloods will form a small ball of blood in the vagina. Some compare this ball to an egg (*atiə mon*); others maintain that it is not more than a mix of fluids ('*aginene medii*': 'it is still water'; '*medii medii*': 'water water').[9] Indeed, to say in Gbigbil that a woman's pregnancy is in the beginning phase of gestation is to say that 'she has water in her body' ('*anene medii a nyol*'). Tellingly, to 'wash the stomach' at this stage is translated as simply 'evacuating the water' ('*mevā medii*').

Rather than considered an *interruption* of a pregnancy, it is explained as the *prevention* of further development into a pregnancy. Rarely would people already talk about an established pregnancy in this phase; at most, what is in the process of being 'formed' could possibly end up in a pregnancy.

Not surprisingly, when asked to draw the development of a pregnancy on an empty body map, my informants were often at a loss about what to draw at one month gestation. Many of them were inclined to give the body map immediately back to me, asking rhetorically how they could draw 'something that is not yet anything'. Probed to designate what they meant by 'not yet anything' they would then try to depict a mess of liquids – as shown by the left and right drawings below. Some women, more or less influenced by Christian notions of immediate life after conception, acknowledged the potentiality of this liquid ball to become a person. They assured me that the movements of the developing ball could already be felt in the lower abdomen during this first month of pregnancy. The drawing in the middle exemplifies this ambivalence of a ball being nothing in itself and yet having the potential to grow into something human-like. After having drawn the circle to the right, Charlotte decided to portray a little foetus inside this ball, while reasoning:

> It is still a ball of blood. It is the foetus that is developing. So maybe I should draw a small person inside the ball. And there is often a cord that links the foetus with the mother. When the mother eats, the food passes through this cord to feed the child. I'll draw it.

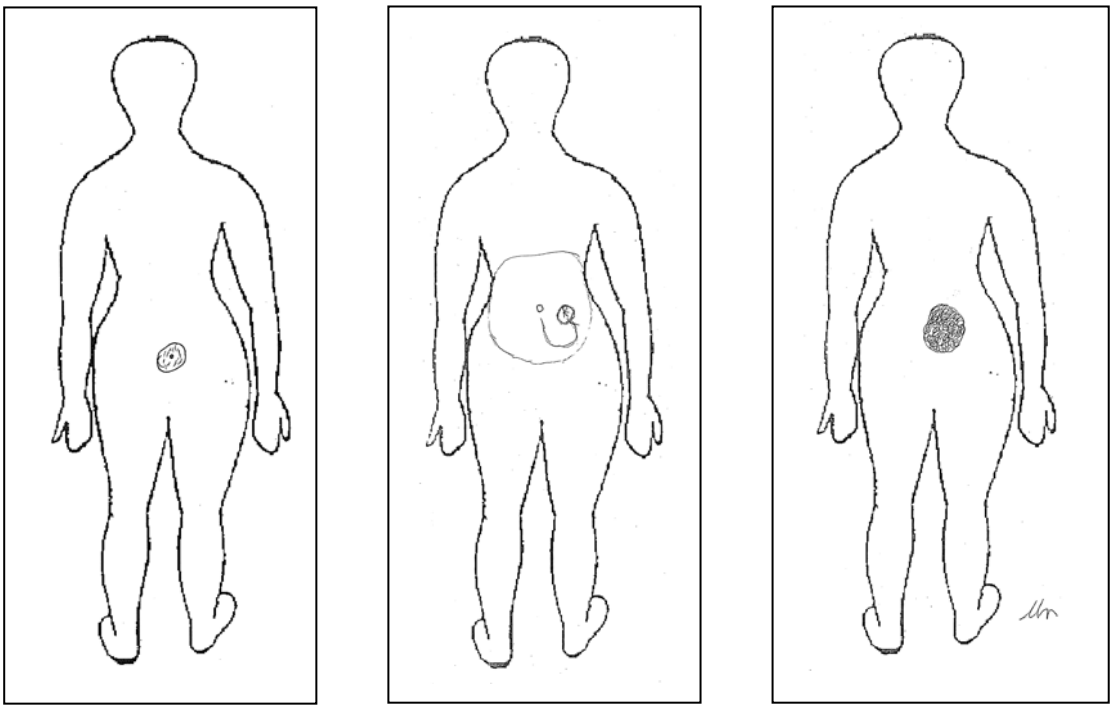

Figure 4 Body maps for a pregnancy at one month

Whether perceived as a complete 'void' or as a potential human being, this 'loose' substance that could potentially become a child (*mon,* pl. *bon*) is called *zəng mon* as long as it does not display clear human forms. *Zəng mon* gradually ascends from the vagina into the uterus and intensifies its movements towards two or three months of gestation – a sign that its development is in full progress. Gradually, the ball is transformed into a lizard-like creature (*sweye*) with a tail in a sitting position. All limbs – spoken of as four paws – are thought to be present, but 'the child is not yet well formed' ('*zəng mon atəka kombā*'). When exactly the child *will* be formed is unknown; the process of forming a human-like *mon* depends mainly on the force of the blood of both the father and the mother – a force which is in itself variable over a life-time. A *zəng mon* of parents with strong blood develops quickly; those inheriting weak blood transform themselves more slowly into *mon*. Of constitutive value is thus the blood that surrounds, nourishes, fills, and protects *zəng mon* until it is completely formed. Further, informants who believe that *zəng mon* resides in the amniotic sac (*akonnā*) – often simply called 'bag of water' or 'plastic bag' in French – attribute the same nourishing functions to the amniotic water as to the mother's blood which surrounds this 'bag' (see the left drawing in Figure 5 below). Next to these liquids, *zəng mon* is also thought to be fed via the umbilical cord, which transfers the mother's ingested food directly, via the bowels (see the middle drawing in Figure 5), or via her blood. Finally, *zəng mon* is thought to feed itself trough an opening in the head – which during birth transforms into the delicate fontanel. The food that a mother ingests directly passes through this opening into the foetus's body and forms the first black stools (*ikokogli*) of the newborn baby. The drawing to the right shows how a lump of food is falling into *zəng mon*'s head.

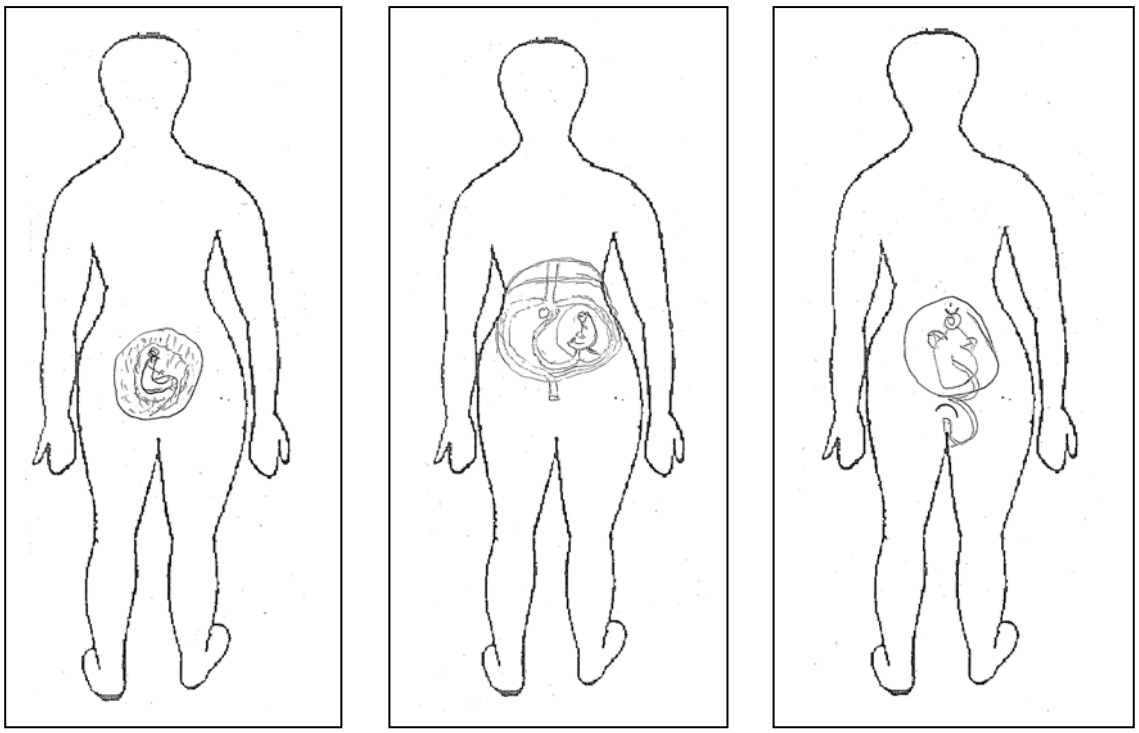

Figure 5 Body maps for a pregnancy at three months

In this developing phase, women are encouraged to have regular sexual intercourse with the father of the growing child; not only will this 'keep the route open' but, more importantly, his sperm (i.e. his transformed blood) is deemed constitutive of *zəng mon*'s developing body. The child will strongly resemble his father if it has been regularly 'fed' by his sperm – especially if this 'blood' is very strong. In this respect, I heard several women say that 'it is the man who gives the child' or 'it is the man who has to work most for the pregnancy'. Sexual intercourse with other men than the genitor – something which is called the 'mixing of the pregnancy' ('*apulā abum*') – should at all times be avoided; the child would reject the smell of their semen and refuse to descend during childbirth (see further pages 82-83).

This essential contribution of the father to the successful completion of the pregnancy has been noted by other studies as well (Aboubakar, 2008; Beninguissé, 2003; Erny, 1988; Godelier, 1992; Krumeich, 1994; Scheper-Hughes & Lock, 1987; Tsala Tsala, 1996). It is often interpreted as the ultimate expression of patriarchal discourses claiming men's superiority and women's dependence on men. Yet, the perceived necessity of intercourse for paternal resemblance should also be situated within a local context of sexual flexibility and marital instability, rendering paternity uncertain and contested but at the same time much valued. In such a context, the appearance of a baby has become an important indicator of who must be the father – and by implication, who must be responsible for, and have rights over, the child (see also Chapter 4). Women who went to school or learnt from their own experiences may, however, dismiss this indispensability of the genitor's semen – or of substitutes such as the gluey *mbol* sauce, ingested by pregnant women when their partner is absent. Through such a dismissal, they often aim to justify their own '*multipartenariat*', which would otherwise be labelled as adulterous or strictly forbidden by *mamas* in the village.

Even when all human features are formed and *zəng mon* has transformed into *mon* – whenever that might exactly happen – the process of growing and filling continues. This process is now essential to provide *mon* with force (*ngul*). In this second phase of foetal development, which informants broadly estimate to start somewhere between three and five months after conception, the child moves toward the upper belly, facing and staying near the spine, where the placenta is believed to be stuck. Here, *mon* becomes almost a separate agent leading its own life: it walks around, sleeps, plays, urinates, refuses or asks for food – all of which can be directly felt by the mother. The mother's food intake is now, next to her continuous supply of blood, deemed increasingly crucial to fill *mon* with force, while sexual intercourse is considered less necessary as the child is already fully developed. Intercourse is even forbidden towards the end of pregnancy since the 'excess of sperm' may stick to the newborn baby and expose one's sexual activities upon birth (see also Beninguissé, 2003, p. 11) .

Only when *mon* is filled with a certain level of force might he or she be able to live *outside* of the uterus. Some attain this level after five or six months, others only at seven

or eight months, and the very slow ones or twins may even need ten or eleven months. Once viability and life force abound, it is *mon* who decides when a pregnancy comes to term (*tun abum*), by initiating childbirth with his or her own force – rupturing the placenta with the nails and subsequently scratching its way out. Thus, the final point of a 'normal' pregnancy does not depend on a fixed time-frame, but varies according to the parents' blood strength and thereby a child's development pace. Asked to draw a seven month pregnancy on a body map, all informants decided to draw *mon*'s head turned downwards 'since some children can be born already by this time'. The right hand drawing reveals the hesitation and uncertainty surrounding gestational timing; after having drawn the head upwards, my informant corrected the foetal position when bystanders reminded her of the possibility of a quickly developed *mon.*

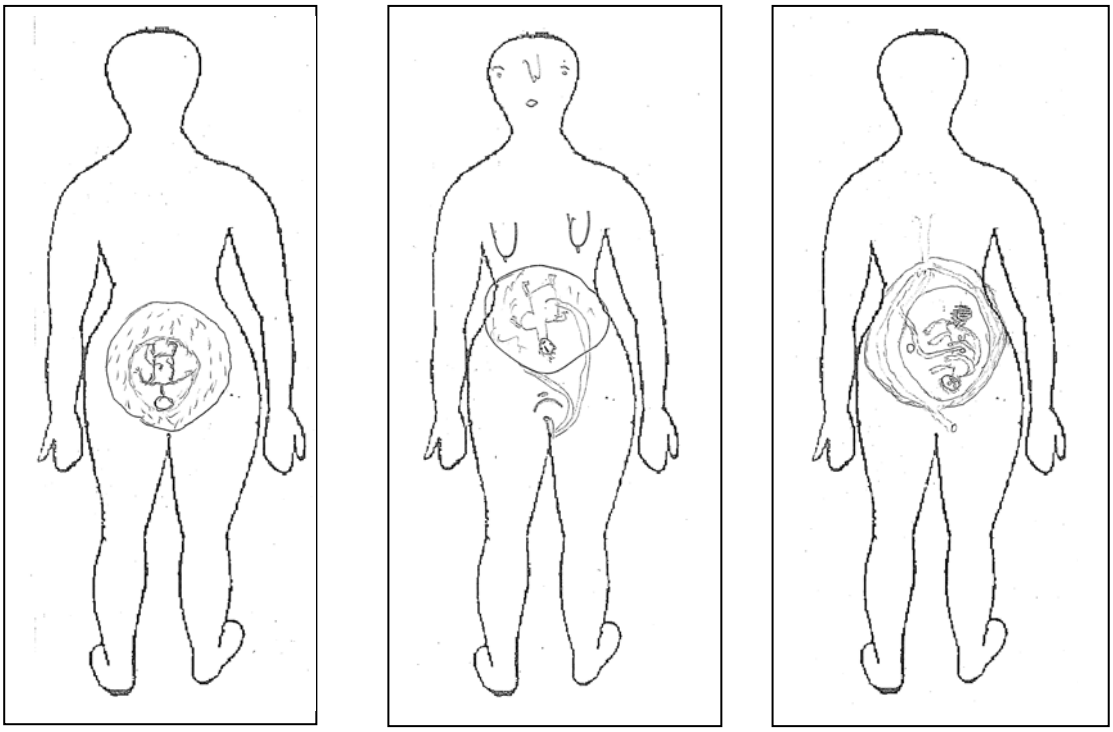

Figure 6 Body maps for a pregnancy at seven months

Following from this flexibility in foetal force-filling, what is called 'a premature birth' or 'being born before the time' is – paradoxically – *not* expressible in terms of fixed months or a particular length of gestation. Instead, it indicates a birth happening before the necessary development of physical substance and life force has been completed – whenever that might have been. Premature babies are therefore described to be 'not hard yet' ('*mon atəka detā*') or 'not filled yet' ('*mon kolonde*'). With the pace of their 'filling' variable and contingent on the blood force of the parents rather than on a set time interval, newborns can be considered premature at either five, six, seven, eight, or even nine months. That it is not *time* but the amount of *force* which determines the

maturity or prematurity of babies, was made clear to me in a discussion with Charlotte during a body mapping session:

> *Charlotte*: If you give birth at five months, and if you have some chance, the child can live. For example, the husband of my aunt was born after five months of pregnancy. He is so old now that people call him 'papa'. When he quarrels with his wife, he says, 'Even if I was born at five months, I am more solid than you are. I can hit you and you will fall'. And it is true: he is very strong!
> *Me:* How do you call these children who are born at five months and continue to live?
> *Charlotte*: *Maman*, how do we call premature children in Gbigbil? [She addresses the co-wife of her father, who answers '*mon kolonde*'.] We call them *mon kolonde.* So the child is not born entirely. Like when you fetch water in a bucket that you haven't completely filled. You can use the same word *kolonde* to say that the bucket is not entirely full of water.
> *Me:* From which moment can you call a child 'kolonde'?
> *Charlotte*: From five months. But even at six months it can be *mon kolonde.* And they often tell me that even some children of seven months can be *mon kolonde.* And still, many women give birth at six months. I know a girl who always gives birth at six months. And all these children are normal and alive. But at five months, you should be lucky.

Charlotte's first example is insightful: the man's assurance that he is solid and strong is not only a reaction to the perception that children born at five months are 'unfilled' and lacking in force, but it also proves that whether a premature baby continues to live or not depends exactly on this amount of physical force present at birth. Of all babies born at a certain gestational age, some may live while others die. Some have reached their full maturity while others are 'born before their time' with too small an amount of force to ensure survival. Although Charlotte reciprocates my time-based questions with time-inspired answers, the inconsistency and indeterminateness of her definition of *mon kolonde* shows that questions about preset periods are in fact not the appropriate ones to ask here. The irrelevance of fixed time-frames as a basis of prematurity and viability was again stressed by Peggy, who carried a pregnancy of eight months and wondered why her baby waited so long to initiate childbirth. Since she had always given birth around seven or eight months, she assured me that her child must already be 'growing old' in her belly now. She contemplated:

> In the hospital they often say that a child is premature from seven months onwards. But that is not necessarily the case. There was a woman here who always gave birth after seven months. And all her children were born normal and alive. Well, and in the hospital, they say that at eight months, the child is dysmature [*dysmaturé*]. So that means that he can already be born, he has already everything, but certain organs or functions are not totally developed. But I don't understand. How can that be? Certainly not all children are dysmature at eight months, since others can be born normally at seven months already.

When I asked her how one could know whether a baby born at seven months would be normal or premature, she answered:

> A premature baby doesn't cry with force. He doesn't have force. Whereas other children can be born at seven months and cry with force. The child is strong as he should be. And the premature baby also has no reflex to suck your breast. He has no force to drink. You should

> even press your breast in his mouth. And his jaws are not well developed. It is still very tender.

These Gbigbil conceptions of vital force are at odds with predefined biomedical categories of viability, which take gestational time or birth weight as its exact, independent, and measurable indicators. Medical specialists have increasingly come to phrase the uncertain survival chances of premature children in terms of calculated risk assessments which downplay physical strength and bodily fitness in favour of measurable time and weight (Downe & Dykes, 2009; Einarsdóttir, 2009). In their paradigm, lack of force is only a *consequence* of a premature birth at a certain, fixed, time interval rather than a *contingent constituent* of prematurity – as Gbigbil embryology has it (see also Van der Sijpt, 2010a; Van der Sijpt, forthcoming-a).

Since my informants determine viability not by linear time or a particular weight, but rather by the amount of life force, which in turn depends on particular social circumstances and physical attributes of related others (see also Chapter 3), I propose to speak about 'contingent viability'. I hereby draw on Bledsoe's notion of 'contingent lives' (2002). Bledsoe shows how in rural Gambia, ageing is perceived to be a result of the traumas encountered over the course of personal history rather than an effect of the passing of linear time. She argues that 'the whims of fortune to which our lives are subjected produce immense unevenness in the pace and character of bodily transformation, both within the span of our own lives and from one person to another' (2002, pp. 22-23). It is exactly this conditional unevenness in the pace of physical transformation that also underlies notions of viability and maturity of newborns in Asung. This 'contingent viability' feeds into the bulk of recent studies which attempt to relativize the linear, teleological, and genealogical assumptions informing Western visions of life trajectories; it resonates with their point that the beginnings and endings of life (or life stages) are *contingent* local concepts, which are never stable or self-evident (Kaufman & Morgan, 2005).

Indeed, Gbigbil views on the contingency of embryology allow for different interpretations of what a pregnancy contains at particular moments, and when human life and a 'soul' enter. Some women point to the commencement of human, Godly given life right at the moment of conception; others consider life to evolve with human forms after three, four, or five months; and still others claim that human life is only proved outside the uterus, when a child is born alive and with enough force. Conceptions about the entrance of a 'soul' within a child are similarly diverse.[10] Some suspect this to happen at the moment of quickening, others reason that it must be at the moment of the first cry upon birth, and yet others assume only a gradual development of personhood over the life-time (see further Chapter 3). The following chapters will illuminate how this multiplicity of interpretations allows for flexible interpretations of not only what is formed during a pregnancy, but also what is lost during its interruption.

For now, it suffices to conclude that the beginning of the lives of Gbigbil babies is not stable, nor self-evident. This is even more so because, apart from its contingency on parental physical attributes, foetal development depends on the behaviour and intentions of mothers and others in the social and supernatural worlds outside. The next section explores these contextual contingencies and situates women's pregnancies within practical worlds where perils are always potentially present.

Pregnancies in practice: social sorrows and secrets

It is ten o'clock in the night; the village is dark and quiet. Writing down my last field notes before going to bed, I am surprised to hear some footsteps approaching my room. As soon as I open the door, Angélique, one of my informants, takes my hand and whispers, 'It has started'. Knowing that this can only mean the labour of her sister Marianne, I quickly take a coat and my torch. Silently, we walk to Angélique's paternal home at the other side of the village, where I find Marianne sitting on the floor, surrounded by her mother and her mother's co-wife. We wait for a whole night in which Marianne is given accelerating remedies from time to time. They seem to have no effect. The next day we sit, laugh, and work outside in the courtyard, pretending nothing is going on inside. But Marianne is left alone in painful labour that does not show any progress. The second night does not bring any improvements either. Angélique and her mother anxiously discuss whether it would be more dangerous to stay at home or to go to the village health centre a few hundred metres away. While her mother proposes to stay home, Angélique insists on resorting to the hospital. Only in the early morning of the second day, just before sunrise, does her mother hesitantly allow us to take Marianne to the doctor. Again, like two days before, Angélique and I walk through the village in silence and darkness – now accompanied by Marianne who is not supposed to be seen by any outsiders. Only half a day later Marianne gives birth to a daughter. Although visibly relieved and happy, her mother can't refrain from grumbling that nowadays young women don't know how to endure labour pains in silence and secrecy – thereby exposing themselves to needless risks. Other women nod affirmatively and Marianne does what she had been expected to do some days before: she bends down her head and keeps silent.

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Apart from maybe its slow unfolding, Marianne's delivery is not an exceptional one in Asung; the actions and interactions described occur frequently in the village. A full understanding of why things happened as they did requires insight into the complexities underlying these actions and interactions. The following aims to clarify Marianne's supposed silence, her sister's interventions and propositions, as well as her mother's fears and hesitations by presenting local perceptions of the 'right' practical management of reproductive matters.

As mentioned in the previous chapter, reproduction in Asung is a contested site: it is a source of hostility or alliance between two lineages, a source of security or insecurity within fragile sexual and marital relationships between two partners, and a source of struggle between co-wives or other female competitors. Management of one's fertility is much warranted in this context where reproduction is constantly surveyed and possibly influenced by others – with good or bad intentions. Before, during, and after their pregnancies, women are constantly being watched, and are watching other women themselves. When bathing together in a river after working in their fields, for instance, women easily notice who is missing, which occurs during menstruation (since women do not bathe in public during their periods), and who has been washing herself there for too long without interruption (indicating a potential pregnancy). Within households, women may share sanitary towels and thus keep track of each other's reproductive happenings. It is in this way that Charlotte's missed period was detected by her sisters:

> I asked myself, 'Why do I always see my period the fourteenth of every month and this month it didn't come? What is it waiting for?' My sisters immediately posed the same questions, since they noticed I didn't use our sanitary towels anymore. My older sister even knew the exact day that I had had intercourse and the days that I had seen my last menstruation, so she concluded I must be pregnant even before I realized it myself.

Given this public scrutiny around menstruation, it is not surprising that women are careful in disposing of their menstrual blood. Many of them prefer to wear loincloths or tear their baby's diapers into pieces (*niinda mekil*), which they can wash at the end of the day and reuse afterwards. Others do wear disposable sanitary towels, but carefully burn them or throw them away in the water of a quick stream or in the deep hole of the lavatory, so that nobody with evil thoughts could get a hold of their blood. Menstrual blood is thought to be a powerful substitute for one's fertility when used in local remedies (*remèdes; bile*). Malevolent others – jealous co-wives or greedy witches – may try to 'steal' a woman's blood and negatively affect her childbearing capacities with it (see further Chapter 5). But menstrual blood also plays an important role in traditional contraceptives that women use to influence their own fertility. Many of these remedies require actions that symbolize the 'blockage' of the flow of menstrual blood, as Daniëlle explains:

> If you want to temporarily stop childbearing, you can take the blood of your menstruation and put it in a bottle. You should bury this bottle somewhere on your field or underneath the cooking fire in your kitchen. A place that only you know, so that you can quickly dig it up when you want to conceive again. Or, if an older woman wants to stop childbearing all together, she could throw the bottle with her blood in a river with a quick stream. Her childbearing will never return and will be blocked for the rest of her life.[11]

Despite the constant control of, and influence on, menstrual cycles by women themselves and by others, it is often not the absence of blood which first signals 'the entrance of a pregnancy' to them. Many women assert that they recognize a pregnancy even before

they determine a missed period. They mention inner bodily transformations such as a quicker heartbeat and an increase in weight and temperature, as well as distorted bodily functions, such as intense fatigue, headache, nauseas, unusual cravings for food, or '*les petites maladies*' ('little illnesses'). Outer appearances also change: the complexion becomes lighter and facial appearance more shining, the navel points out, nipples blacken, and a black line appears from the pubic area up to the navel or higher (see also Aboubakar, 2008, p. 43; Beninguissé, 2003; Fru, 2008, p. 45; Krumeich, 1994). The visible signs through which they detect beginning pregnancies in themselves and others are multiple. Not surprisingly, the experienced eye – especially those of older women – will easily remark that a woman 'has become more beautiful' and that 'there has to be something' from a very early moment onwards. These *mamas* do not refrain from calling young girls passing by on the street in order to warn them that they 'have eaten bananas' ('*obəng dyī ayola*'), 'have collected something' ('*obəng vubele*'), 'have a baggage' ('*onene bəppə*'), 'are well-positioned' ('*osō itəlka*'), or 'are already women' ('*osō munka*').[12] Allusions to a pregnancy always remain symbolic; to pronounce a pregnancy by its proper name would expose a hidden and vulnerable state and thereby possibly threaten the fragile developing *zəng mon* (see also Eschlimann, 1982, p. 53). Yet, women know all too well what the metaphors of their *mamas* mean.

Sometimes, however, women do not immediately recognize their pregnant state. This can especially be the case when they are pregnant for the first time. When I met Joséphine, a 23 year old school-going woman, she claimed to have been carrying her first pregnancy for three months. Asked how she had realized she was pregnant, she told me:

> I really had no idea that I was pregnant. I rather thought I had a fibroid in my belly that sucked my blood. So I started taking indigenous medicines for a fibroid. At a certain point my elder sister came to me and told me I had changed. My skin had become lighter and my breasts had grown bigger. She asked me, 'How is it? Are you pregnant?' I told her I might have to be operated to see what's inside my belly. My sister brought me into the house and asked me to lift my shirt. She saw how my navel was pointing out and gave me a mirror to look at it myself as well. I still denied and persisted I was ill. She laughed and said, 'Which illness? Which operation? There is something growing in your belly, but it's not a fibroid. You have already eaten bananas'. And until now she still makes fun of me. Every time she reminds me that in a few months time, my real 'operation' will be due!

When we went for an antenatal visit the next month, it turned out that Joséphine was already in her twenty-seventh week. Her 'operation' thus happened months earlier than assumed. Retrospectively, many informants claim to have borne their first babies much earlier than expected – which is probably often the effect of a belated recognition of their first pregnancy.

Whether they know it from the very onset or only later, pregnant women will do everything to hide and deny their initial state to outsiders. Since an early pregnancy is considered to contain 'only water and blood', it is very liable to destruction by jealous, infertile, or otherwise malevolent witches, who are generally known to 'suck people's

blood'. This threat to fertility especially – and somehow paradoxically – comes 'from within', as witches are believed to operate on the most intimate level, preferring to attack close relatives (Geschiere, 2003). Therefore, a woman's family members, but even more so those of her husband with whom she interacts on a daily basis, should remain ignorant of the pregnancy as long as possible. This distrust of an expectant woman towards her in-laws in particular – *despite* or perhaps *because of* their intense desire for children – works also the other way around. Should a woman reveal her pregnancy very early to her in-laws and miscarry afterwards – for whatever reason – her family-in-law may suspect this 'outsider' of either having deceived them by inventing a pregnancy or of trying to abort the pregnancy to deprive them of much wanted descendants. In contrast to what is stated by other studies in Cameroon (Aboubakar, 2008; Beninguissé, 2003), there are some cases in which Gbigbil women purposefully inform their male partners of the pregnancy in an early stage; quick announcement of a pregnancy to a man can be a woman's strategy to 'bind' him to her, convince him of his paternity, and make him more responsible – especially when her relationship with him is informal or unstable (see further Chapter 4). In general, however, it is in a woman's interest to remain silent and deny every allusion to her changed appearance until *zəng mon* has transformed into a stronger and well-formed *mon* – and the pregnancy becomes more stable, secure, and visible (see also Adetunji, 1996; Beninguissé, 2003; Chapman, 2003; Tsala Tsala, 1996).

Only when the protruding abdomen becomes confirmed, acknowledged, and shared with others, a pregnant woman acquires a status as such in the community.[13] Now that denial of her pregnant state becomes unsustainable, the initial secrecy and silence will give way to public jokes, social interferences, and critical recommendations (see also Aboubakar, 2008, p. 44; Beninguissé, 2003). Especially older women in her own family and those in her husband's compound will keep a watchful eye on her – for two reasons. First, surveillance is deemed necessary because other people may smell 'the odours of pregnancy' or visually recognize the growing belly (even though it will be anxiously hidden under the typical wide *kabba* dress that the pregnant woman will now start to wear) and want to do harm. Not only could witches wish to 'devour' the well-formed *mon* in their nightly gatherings, but those desiring a child themselves might mystically 'steal' the foetus and place it in their own womb – after which the originally pregnant woman would see her belly disappear.

Second, control by others is warranted because the mother-to-be will herself be subjected to many prohibitions. As *zəng mon* has by now more or less transformed into a human-like *mon* dependent on, affected by, and imitating its mother's deeds, prohibitions (*bikil*) pertain to the mother's moral behaviour, daily activities, physical appearance, and food intake. While prescriptions are multiple and sometimes even contradictory, they all aim to preserve both mother and child's well-being and enhance a successful gestation and delivery (see Appendix IX for a list of pregnancy-related prohibitions in Asung, and several reports by the Cameroonian Ministry of Public Health (1993a, 1993b, 1994, 1995)

as well as Beninguissé (2003) and Tsala Tsala (1996) for comparable food taboos in the region). For instance, the mother-child analogy prohibits laziness or standing still in the door opening since this would lead to a prolonged and difficult labour; wearing bracelets or necklaces would wrap the umbilical cord around the child's neck; eating porcupine would lead to the birth of a baby with a skin disease; talking about miscarriages would provoke one; and quarrelling with people would make *mon* refuse to be born quickly. Such regulations reveal how not only a mother's physical characteristics (such as the amount of blood and force), but also her social assets and behaviour are believed to affect foetal development.[14]

After six or seven months of gestation, a pregnant woman often leaves her husband and in-laws to go and 'wait for the delivery' ('*atake bong abial*') with her own family. That this tradition holds especially for the first pregnancy a woman carries for a particular man reflects the initial distrust between a (potential) daughter-in-law and her in-laws that has been outlined in the previous chapter. While Eschlimann (1982, p. 66) has interpreted the custom in terms of embarrassment to give birth in front of the in-laws and confirmation of matrilineal blood ties, in this East Cameroonian setting where few people are present at the moment of birth, and patrilineal claims are more prevalent than matrilateral ones, it is suspicion and concern with pre- and post-partum care that mainly inform the preference for giving birth in one's own family (see also Beninguissé, 2003, p. 31). Here, women expect to get more rest, privacy, better care, and intimate knowledge of indigenous medicines enhancing a quick and safe delivery. These 'remedies of the vagina' ('*bile ndjol*') are inserted or evaporated into the vagina, 'vaccinated' in the lower back or waist, carried in underwear or in cords around the hips, or introduced into the rectum through an enema (see also Arreyanhyoh, 2007), in order to enlarge the pelvic opening during childbirth.[15] Since pregnant women do not have sexual intercourse during this last phase of pregnancy, these remedies are deemed essential to 'keep the route open' and help *mon* to quickly find its way out at the moment of delivery.

Photo 4 Pregnant woman administering remedies through 'vaccination' in lower waist

The intimate sociality of preparation for childbirth stands in sharp contrast with the ideal of solitary management of childbirth itself. Many older women proudly relate how in earlier days, women were so brave as to give birth alone in the bush. They proved their womanhood by not showing the labour pains they suffered – self-mastery, resilience, and endurance are reported to be appreciated indicators of women's dignity in this region (Johnson-Hanks, 2006) – by silently withdrawing themselves behind the huts, by giving birth all alone in the fields or on the coffee plantation, and only calling for help once they needed somebody to cut the umbilical cord – or even doing this themselves. While other studies mentioning the ideal of solitary birth in African settings relate how this grants (or granted) women the power to dispose of unwanted or abnormal children (Bleek, 1976; Eschlimann, 1982; Olivier de Sardan, Moumouni, & Souley, 2000; Sargent, 1989), I never heard my informants mention this possibility for infanticide.

Nor did I hear of any solitary births actually happening while I was in the field. But it remains a norm with which even the youngest women are still confronted – either because older women impose it on them or because they themselves cling to the ideal. Especially when they are confident in having enough experience in childbearing, they might wish to 'do like the others'. Sophie, a 27 year old woman, relates the experience of the birth of her fourth daughter as follows:

> A woman can give birth by herself and other people will only find her afterwards. The child has come out and even the placenta has come out. She will then raise and start to shout that people have to come to help her. Even Celestine [her younger sister] did it, right? She gave birth to her first daughter all alone, behind the house. She called out, 'Come-oh, come-oh!' People found that the child was already born. Eke! I also wanted to try this. So I did not tell anybody about my labour pains. I was there, I sat, I just endured and endured while the pain persisted. Ha! No, you must be very courageous huh? I didn't succeed. At nine o'clock in the evening, the child said, 'You're lying, I want to get out now'. I want to sit, no. I want to raise, no. My mother and sisters ask me what's wrong. I ask them, 'Ever since I have been talking with you, haven't you noticed something?' Everybody was so surprised to know I had been in labour all the time! They thought it was a joke, whereas the child had already said, 'You lie, I will get out now'. So they had to run and call my older sister and mama Adèle [a traditional birth attendant]. I pushed once and it was over. I already had my child in my arms. The next morning everybody was surprised. Nobody had known and I had endured a lot all alone.

The ideal of showing independence, force, and endurance notwithstanding, most women, like Sophie, inform a mother or sister when contractions intensify. They install themselves in the kitchen or in a secluded room in the house, where the entrance of men and children is now strictly prohibited (see also Aboubakar, 2008, p. 53; Beninguissé, 2003). As soon as the delivery is near, a mother or sister will run to call a – previously warned – traditional midwife (*munka mebyala*) for assistance. These 'midwives' are often older women (*les mamas*) in the family, who have gathered experience throughout and after their own childbearing years.[16] The parturient is installed on the floor and supported by a woman – her mother or sister – sitting behind her with open legs and holding her arms. The birth attendant will wait in between the parturient's legs to 'catch the baby'

(see also Figure 7 as well as Fru, 2008, p. 48). After removing the placenta and cutting the umbilical cord with a razor blade – previously a bamboo stick or sharp leaves called *sisongo* – the mother will be washed and her baby wiped and covered with many clothes and towels in order to stay warm.

Whether they give birth alone or in the company of others, women do recognize the risks that childbearing involves. Maybe even to confirm their perseverance, women often told me that '*l'accouchement, c'est la mort*' ('birth is death'). This point was made clear to me when I coincidentally wore black clothes while assisting Marianne during her labour pains. When we silently left Marianne alone in the house and installed ourselves in the courtyard, Marianne's mother nodded her head and whispered to me, 'You did well to wear black clothes today Erica, because we're all mourning'. This association between birth and death is not farfetched; many women in this region *do* die during pregnancy and childbirth. Although it is difficult to obtain reliable maternal mortality figures at the local level, the national estimate of 669 deaths per 100,000 births (Barrere, 2005, pp. 232-233), as well as the many stories in the field about women dying following complications in childbirth, and the several 'near miss' cases that I witnessed myself are indicative of the situation.

Since all women agree that labour is 'not really a pain that should last on you', what is deemed essential is that deliveries happen *quickly.* Next to the many preparatory 'remedies of the vagina' aimed at enhancing a quick delivery, there are many ways of speeding up the descent of the child during labour itself. In the long nights that we sat around Marianne, Angélique was constantly preparing and administering remedies to her sister. First, Marianne had to drink a mixture of garlic, onion, and ginger which is thought to 'pick' the child; then, she had to rectally insert rasped coco yam (*mekappa*) which is believed to 'scratch' the child; after this, another enema of small peppers (*sonde*) and soap (*soppo*) was administered to 'heat' the child; honey was constantly near to 'energize' the child; every now and then, Marianne's belly was gently tapped by her mother or the traditional birth attendant to 'wake up' the child; and finally, when we all wanted to sleep, Marianne was instructed to walk around in the dark room and jump if she would not feel any more movements.

It is exactly complicated, prolonged deliveries such as the one of Marianne that are intensely feared by women. Not only is an *accouchement difficile* (*abial yaka*) physically damaging and tiring, but it also raises social suspicions and complications. As mentioned earlier, a complicated delivery may be caused by a woman having had sexual intercourse with men other than the father of the child (*ibamba*). Joséphine, whose delivery turned out to be not only much earlier but also much more complicated than expected, almost cried when she told me that some women had come to the hospital – where she had finally been transported – to ask her to confess her sexual activities so that the child could eventually be born. Daniëlle remembers how she used to 'mix' her first pregnancy and how she prevented complications during birth:

> When I had my first pregnancy, I left the father of my child in Bertoua. I went back to my mother here in the village. Well, I found another man here. I also had intercourse with him while being pregnant. You see? So I asked my mother, 'I have mixed my pregnancy, what should I do?' She told me, 'In any case, I will search for remedies. When the pregnancy will be at term, I will give them to you'. These were remedies that I had to pee on, every morning, on the same spot. When you place them on the ground, you pronounce the name of the person who made you pregnant. Only his name and no other! And then you pee on it. I tell you I didn't have any problems; my daughter did not ascend at the moment of delivery. But if I wouldn't have done this, she would have risen up in my belly. And people would tell me, 'You have to cite the names of the men that you slept with outside [of marriage]. You should not hide anything'. Then, they would rub some remedies downwards over my belly and the child would descend immediately. So I would be obliged to confess and that would make me so ashamed. And this is where you see that many young women die during childbirth. They prefer to shut their mouth out of shame and die with the child in their belly.

Not only the transgression of sexual taboos might lead to complications during birth, but also the non-adherence to many other prohibitions and prescriptions during pregnancy (see Appendix IX), as well as the non-application of *bile ndjol*. Most complications, however, do not stem from a woman's own negligence, but from mystical interventions of malevolent others. Witches, jealous co-wives, or people with a 'bad heart' might try to 'block' or 'attach' the delivery (*akomma abial*) through symbolic or occult actions. In order to prevent the pregnancy from 'descending', they might suspend attributes symbolizing the parturient's fertility – for instance, her underwear or the stone used for grinding ingredients (*akok*).[17] Unless they undo their action by taking down the attributes, the child will not 'find its way out' and may die *in utero*. It is the fear of such interventions that inspires women's preference to keep silent during labour pains and to give birth all alone, far away from people with bad hearts and bad intentions.

Yet witchcraft accusations can also turn towards the pregnant woman herself. Since the entity of witchcraft (*ivū*) is thought to be located in the belly, unborn babies might become the victim of its greediness during childbirth. The crab-like creature, which people often imagine the devastating power to be, might keep a hold on *mon* and refuse to let it go. The only way to solve such complications is to confess to a traditional birth attendant to be a witch – something midwives claim to feel immediately during their first '*toucher*'; *ivū*, positioned in front of the child to prevent its descending, will 'bite' their fingers as soon as they insert them in a woman's vagina. Only after attaching certain remedies to the hand, which make the witchcraft 'flee' upwards in the belly and lose track of the child, can they help the child being born normally. In other cases, *ivū* is told to leave the vagina and vomit the child on the ground, while rendering the birthing woman in mortal danger as long as it remains outside of the uterus. Other women are noted to have given birth to an animal or an amorphous creature because of their *ivū*.

Situations in which a woman's occult powers are revealed through difficult births are considered very shameful. This is also the case for confession of another form of witchcraft, called *bikaka*. Mama Denise explains:

> Sometimes, when you are young, you are given witchcraft on the basis of certain conditions. For example, that you will die during your second delivery. Or that you die whenever you will deliver a boy. You can give birth to girls during your life, but as soon as you carry a boy, you will feel it and you know that your moment is near: as soon as the boy will be born, you will die. It is part of the pact. Your death can only be prevented if you confess. In that case, people can treat you. Your child might still die but you stay alive. Nevertheless, this is very shameful![18]

Consequently, women are not allowed to ask for the sex of the child after delivery; their curiosity would make them a suspect of having *bikaka*. As soon as the baby cries, it is the midwife who is supposed to indicate the sex of the child, after which those surrounding the parturient will go outside and announce the birth to the people waiting for the news.

In the immediate post-partum period, the new mother (*yal*) and her newborn baby (*tiəngli mon*) are considered to be extremely vulnerable – spiritually and physically. Both are therefore subjected to strict surveillance and prescriptions and will preferably stay for several weeks with the woman's family members (see the next chapter for protective measures regarding the newborn baby). *Yal* is believed to be especially weak in a physical sense; the flows of blood and breast milk – a transformation of blood – during delivery and the nursing period directly diminish her amount of blood and, by implication, force. There are several indigenous methods to restore blood and force levels in these moments of intense depletion. First, daily massages (*ba abum*) are considered indispensable to heal the 'wound of the placenta', evacuate all the 'bad' blood from the uterus, and allow *yal* to regain some strength (Aboubakar, 2008, p. 67; Beninguissé, 2003, p. 37; Laburthe-Tolra, 1985).[19] Second, various indigenous remedies are believed to 'clean the stomach' or replenish the blood reservoir with fresh and strong blood.[20] Next to consuming nutritious food like green leaves, women who are recovering after delivery regularly drink concoctions containing, for instance, papaya or its leaves, eggs, milk, red wine, or mashed tomatoes – substances that resemble red blood or white milk.

Photo 5 Remedy for blood replenishment: red concoction from boiled leaves

Although these remedies enable the body to replenish its blood reservoirs, they are only partial substitutes; one can never attain the previous level of force once a certain amount of blood has been lost. Or, in one informant's words, 'It is only indirect. It doesn't give you blood like when you receive blood by transfusion. Compare it to vitamin pills: you can take them, but you will only gain weight some time afterwards'. It is in this sense that hospital injections are deemed most effective after deliveries. As needles enter the veins directly, they are thought to offer the quickest boost of vitamins, blood, and force. Ideally, many women prefer to visit the health centre after childbirth; post-partum care will keep them energetic, strong, and well prepared for their next pregnancy. The following section explores if, why, and how women opt to deploy biomedical services *before* and *during* delivery as well. What are the perceived advantages and disadvantages of biomedical reproductive health care in this setting, where pregnancies are surrounded by many social stakes and dangers?

Pills, pictures, and prescriptions: a continuum of care

Asung's health centre, like all *Centres de Santé Intégré* in Cameroon, is supposed to provide basic but comprehensive mother and child health care. The clinic offers antenatal services including measurements and diagnostics of pregnancy parameters (blood, urine, temperature), and is endowed with a delivery room, delivery table, and some rudimentary medicine needed for basic obstetric care (*SOB: soins obstétricaux de base*) and post-partum services.

Photo 6 The delivery room in the health centre of Asung

A total coverage of monthly antenatal consultations during the entire pregnancy costs approximately 1,500 CFA Francs (around 2.25 Euros); for normal hospital deliveries, women should reserve 5,000 CFA Francs (around 7.50 Euros). A proof of antenatal check-ups is officially required in order to be admitted to the hospital for a delivery. In practice, however, it depends on the receiving doctor – if there is any – and the circumstances in the clinic whether one is or is not received without a *carnet* (maternity record book). Both

doctors who were appointed during my fieldwork periods – the first one being a Gbaya man from the North, the second an Eton from the Centre – had had some form of obstetric training, and were from time to time assisted by a nurse from a neighbouring village, and, if need arose, a Gbigbil pharmacist with some obstetrical experience. On a yearly basis, they offered antenatal services to around a hundred pregnant women, of whom only a few would give birth in the hospital. Patients with gynaecological problems such as pre- and post-abortum bleeding were even scarcer, despite the presence of post-abortion care in this centre since its inclusion in the 2001 'Policy and Norms of Reproductive Health Services' (see Appendix VIII for hospital statistics and Chapter 1 for more information about guiding health policies). In the following, I will explore what attracts those few women to biomedical reproductive health care and what keeps others away. I will describe how hospital services do or do not connect to local experiences and expectations of pregnancy development and management.

First of all, the physicality of biomedical examinations corresponds with women's material pregnancy management. Despite their social implications, pregnancies in Asung are largely experienced and evaluated in terms of their materiality. I have described how, in their daily lives, pregnant women are preoccupied with the assessment of their bodily fluids (vaginal secretions, water, blood, and blood balls), with the diagnostics of their bellies (form, volume, colour, temperature, appearing lines), and with the constant interpretation of physical symptoms (heartbeat, fatigue, headache, nausea, cravings). Not surprisingly, the management of pregnancies is largely physical as well; bellies are touched, liquids carefully observed, and numerous remedies 'vaccinated' into the skin, introduced into the rectum through enemas, inserted or evaporated into the vagina. This materiality also pervades biomedical antenatal care; the tests of blood and urine, the touching and measuring of the belly, the injections that enter directly into the veins, and the pills that should be swallowed or vaginally inserted add to a Gbigbil repertoire of pregnancy interventions and evaluations. Instead of being two opposed forms of pregnancy management, 'indigenous' and biomedical interventions thus form a continuum of concrete care – complementary rather than competitive (for a similar conclusion see Adetunji, 1996).

Second, biomedical antenatal care offers visual facilities that give direction to women's reproductive uncertainty and speculation. While many informants would answer my questions about female physiology and embryology with claims that 'one cannot see what is in the belly' or that 'our bellies are too deep to know', proponents of antenatal care would posit that it is exactly in the hospital that 'they can see the condition of the belly' or that 'they see how the child is positioned in the belly'. In this setting where normally only witches are believed to be able to 'see' the inside of the uterus, visual biomedical technologies – especially ultrasounds that are offered in urban hospitals – are accredited great powers and insight. The authority of these visual technologies almost paradoxically leads to a *blind* trust of women, characterized by ignorance of the exact

process and mere acceptance of reported results. My informant Joséphine, for instance, expressed her surprise and indignation after her first ultrasound in the provincial hospital of Bertoua, during which she learned that she had been pregnant for seven instead of the supposed three months. Not only had she not expected the doctor to uncover her belly and 'pour water over it'; she could also not understand that he needed only five minutes to 'see' all the information and then simply sent her home again – a trip of several hours. That Joséphine could make no sense of the ultrasound was not surprising, as the doctor had turned the screen away from her in order to explain his measuring techniques to me. Nor was it surprising that she did not suspect the black picture in her maternity record book to be a photo of her foetus; it was simply not told to her. What Joséphine *had* understood was that her child 'looked fine' and that she should now quickly urge her boyfriend to prepare the layette.[21]

A third attraction of biomedical supervision of pregnancies lies in its promise of speedy management at the moment of birth. In this respect, women applaud hospital deliveries for two different, though opposed, reasons. Those fearing prolonged deliveries claim that hospital births are potentially quicker and safer due to the presence of labour inducing measures (such as oxytocin). Rather than experiment at home with 'indigenous' remedies, of which the substance and required dose are often unknown, they consider it more reassuring to ask a knowledgeable doctor for a quick and effective intervention. The injectable form of this intervention only reinforces its perceived effectiveness – as medicines that 'enter the blood directly' are deemed more powerful. Labour inducement is indeed not rare in Asung's health centre; more than once I witnessed the doctor speeding up a woman's labour – though most often he did so to prevent interruption of his own (travel) plans for the day.

While equally denouncing the obsession with quick deliveries 'at home', other women recommend hospital deliveries exactly because of the non-interventionist approach. They applaud the fact that 'doctors simply wait for the child and catch it' without many accelerating interventions. Especially younger women with some degree of education or boyfriends in the city – who often insist on hospital deliveries – as well as older ones who have encountered problems in childbearing, are critical of giving birth 'in the village'. Their criticism is fed by the doctor who regularly scolds *mamas* and *matrônes* (traditional birth attendants) for keeping their daughters hidden 'in the village' for too long and only sending them to the hospital in case of complications – thus increasing the mortality and morbidity risks for both the birthing woman and her foetus. During the post-partum vaginal exam of a woman who had lost her baby in a dramatic delivery, the doctor's remarks are unambiguous:

> *Woman* [screaming]: Isn't it all right now, doctor? Oh, God! It hurts! Gently, please.
> *Doctor* [inserting his whole forearm in the vagina]: Is it your mother who made you deliver? Huh? It is pity that makes me take care of you now. But I tell you: you shouldn't go there anymore. The village is dangerous. The other day, they almost assassinated a pregnant girl there. The girl wanted to come to the health centre. The old *mamas* told her not to go.

Sister of the woman: She was alone; she couldn't act.
Doctor: Even her husband wanted to come here.
Sister: You know, we cannot contradict the old *mamas*. For the husband, it's his wife. It is not his daughter.
Doctor: Yes, up to the level that the *mamas* did an episiotomy with their nails! You know, the child that has passed [i.e. died] could have accused his grandmothers in court. Just like this one here [i.e. the woman he is treating]. It's very bad. She stays in the village for her first delivery, whereas she has no passageway. And I had already explained her problem to her! [He inserts a compress into her vagina and demands her to descend from the delivery table. After offering her sister some gloves and bandages, he orders the women to go.]
Sister: What should we do with these gloves? We don't use that in the village.
Doctor: No, you can only cut with your nails instead! That's organized assassination! [To me:] They wanted to deliver at home but it didn't work out in the end, so they came here only in the very last minute. Before that, the old *mamas* were in a hurry and scolded the girl that she should push. Foetal suffering and more and more. No wonder the child has died!

The doctor's critical stance on home deliveries and the work of untrained birth attendants is reflected in many governmental and non-governmental messages on maternal and child health in Cameroon. Advertisements like the following, displaying 'village' practices as harmful and risky, are well distributed over the country:

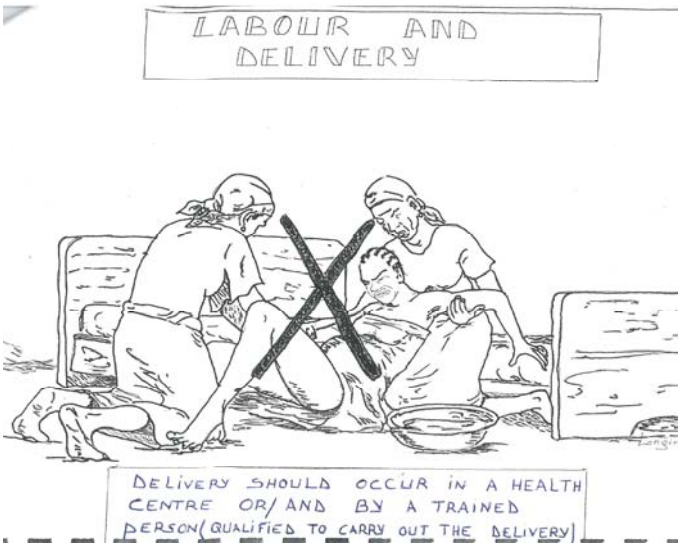

Figure 7 Advertisement against 'risky' home deliveries

Source: *Manual for the dissemination of information regarding the beneficial and harmful impacts of traditional practices affecting the reproductive health of the woman in Cameroon* – distributed by Cameroon Medical Women's Association (1997).

'In the village', however, it is exactly the act of going to the hospital and thus publicizing a pregnancy that is often considered risky for both the mother and the baby. As a visit to the centrally located clinic on Wednesday (the day of antenatal visits and vaccinations) while wearing a *kabba* (a wide dress for pregnant women, required for hospital visits) is easily remarked by outsiders, it might expose pregnant women to the bad eyes of

witches. Women therefore seldom start their antenatal visits during the recommended first trimester of pregnancy. For deliveries, they preferably approach the centre when it is dark, during the night or the early morning – like in Marianne's case depicted above. Few people will visit them there, so that their presence can remain concealed until the first cry of the baby is expelled. The more people know about the labour, the more risky it becomes.

Other reasons for not visiting the dispensary for antenatal care or deliveries include embarrassment in front of the male doctor, lack of French fluency, lack of knowledge of the precise date of conception, lack of money, or simply the absence of any complications during pregnancy – motivations that have been mentioned by studies in different locales as well (Adetunji, 1996; Asowa-Omorodion, 1997; Beninguissé, 2003; Chapman, 2003; Olivier de Sardan et al., 2000). A delivery in a hospital requires certain preparations: women are obliged to bring a pullover, a head scarf, a *kabba* dress, white underpants, sanitary towels, a bandage, a compress, a pair of gloves, two towels, diapers, and a complete set of baby clothes. Further, as mentioned, they should have attended antenatal care; the doctor may refuse to assist labouring women who arrive without a maternity record book. The association of hospitals with complications by many inhabitants of Asung has a paradoxical effect: as long as pregnancies seem uncomplicated there is no perceived need to make use of antenatal services; yet, when complications (unexpectedly) arise during labour and people ultimately resort to the hospital, they risk being deprived of the help they are looking for because of their absence during the antenatal period.

Apart from these practical considerations and constraints, women may also contest the knowledge and authority of the doctors. With a history of many temporary doctors – some of them good, some villains, others utterly corrupt, and all of them 'outsiders' to the village – in mind, women have become sceptical of their promises and positions (see for similar findings Jeffery & Jeffery, 2010). Their claims – about the sex or number of foetuses, for instance – become even more distrusted as visual devices are absent in the village centre. Mama Georgette, mother of ten children, recalls her disbelief at the doctor's announcement of her twins (*mīvīyaa*):

> I didn't even know there was still another child. Although, during the [antenatal] visits, the doctor had already told me, 'Hey, madam, attention! Go and tell your husband that you have two children'. I asked him, 'Why, my doctor?' He said, 'There are two respirations in your belly. You carry a man and a woman. One respiration is strong, so it is a man. Here, the respiration is slow, so it is a woman'. I said, 'Heeeeey, what can I do?' I started to tremble. I didn't believe him. During the night, I constantly tapped my belly. And when I ate, it began to move. The side of the man moves. It calms down again. The other side also starts. I ask myself, 'Is the child turning in my belly?' I pose this question to my husband. He says, 'Well, since you have given three daughters, maybe this time it must be a boy'. Whereas these were *two* children! The day of my delivery, the girl was the first one to come out. My sister-in-law wants to push out the placenta and starts to scream, 'Hey, Georgette, there is still something hard in your belly'. I said, 'I don't know'. What the doctor had told me, I hadn't told them oh! As the girl had come out solely, I told myself in my heart, 'You see, the doctor has lied to me'.

> But I felt already how the child descended and when I pushed just once again, the boy appeared. The doctor had not lied to me. I had two children.

Further, biomedical recommendations are contrasted to the daily '*conseils*' (advices) of the village *mamas*. In December 2008, an Eton doctor arrived in the village with a clear motivation to 'get all pregnant women to the hospital'. In one of his first educational sessions, he informed pregnant women about food habits, hygiene, clothing, and antenatal visits. While most attendants silently listened to his advice, some courageous ones articulated the discrepancies between his information and traditional prescriptions, in questions such as:

- *I have a problem. I carry my first pregnancy. Here in the village, the mothers often tell me that I shouldn't cut my nails, especially not during a first pregnancy. If I would cut them, the child would not be able to tear apart his placenta on the day of delivery. I would like to know if that's true.* [In reaction to the hygienic prescription to regularly cut nails during pregnancy]

- *Here in the village, they tell us that we shouldn't eat eggs, since the child will be born with dirt in his eyes. His eyes will be closed. What to do?* [In reaction to the recommendation of a protein rich diet during pregnancy]

- *There are some people who say that it is not even allowed to 'play', to 'taste the ball' towards the end of pregnancy. Is that true?* [In reaction to the metaphorical advice of 'playing football', i.e. having sexual intercourse, only intermittently during pregnancy]

While the doctor dismissed these traditional prohibitions as *kongossa* – a popular word for gossip and false rumours – some youngsters rejected them as pretexts for witches to exert their occult powers. In their view, the prescriptions elders impose on them are in themselves neither effective nor harmful; their non-adherence, however, would provide an opportunity for witches to afflict the pregnant woman or 'spoil' (*gâter*) her unborn child while remaining undiscovered – since people would believe that the negative consequences had been caused by transgression of pregnancy taboos (see also Ministère de la Santé Publique Cameroun, 1994). Such interpretations show how the contradictions of pregnancy-related recommendations make many young women sceptical – towards biomedical staff and towards their own grandmothers. At the same time, the multiplicity of prescriptions allows them to strategically deploy one interpretation or the other at particular moments; they variably invoke 'knowledge of the ancestors' and 'knowledge of the whites' as justifications for their own practices or convictions. Thus, biomedical institutions add not only to the repertoire of concrete *care*, but also to the repertoire of *conceptions* – thereby allowing for different navigations and interpretations of pregnancy and childbirth by different women, and at different moments in time.

The strategic use of biomedical discourses and services in women's pregnancy navigations became clear to me when I accompanied the five month pregnant Charlotte to her antenatal visit in a private clinic in Bélabo. Again, I was surprised about the lack of

information she received while undergoing several examinations, and the lack of questions from her side; she assumed everything was 'normal' as long as routine examinations were not interrupted or commented upon. What seemed to interest her more was the amount of money her boyfriend would give her for the medicines and check-ups. When we met him afterwards, she reported a price for prescribed medicines that was 3,800 CFA Francs (around 5.50 Euros) higher than what she had actually paid, and untruthfully told him that the doctor had asked for an ultrasound in Bertoua. At that time, an ultrasound in the provincial hospital of Bertoua cost 7,000 CFA Francs (around 10 Euros) – excluding the travel costs of 2,200 CFA Francs (around 3.50 Euros). While many men deem an ultrasound necessary only in case of serious reproductive problems, women assert or invent a need in order to claim, test, or use the responsibility of their partners – especially in fragile, informal relationships with relatively well-to-do *gros poissons* (see further Chapter 4). Charlotte succeeded; satisfied with the 5,000 CFA Francs her boyfriend gave to her, she laughingly whispered to me that she now had to make sure he would not ask for proof in her *carnet* (maternity record book) or insist on accompanying her to the clinic next time.

Not all women whisper, however. On the contrary, their strategies may be very well known by, or openly shared with, doctors and others. While I was having a chat with the Eton doctor of the health centre in Asung, Louise, a pregnant neighbour of the hospital who had never attended antenatal care, joined us on the wooden bench in front of the dispensary. When the doctor inquired about her well-being, the following conversation ensued:

> *Louise*: Today, I suffer more than on other days.
> *Doctor*: That's because you don't come to the hospital.
> *Louise*: I don't have money. It is hard for me to find even a hundred francs [0.15 Euro cents].
> *Doctor*: Don't you have cassava on your field which you can sell?
> *Louise*: I am planning to sell some this week in Dangi [neighbouring village where her boyfriend lives]. I am searching money for the transport now. I will sell. Oh, *dokta*, can't you prescribe everything that you would like to prescribe in my maternity record book? Everything! Even if I don't take it. But I will bring this to Dangi and present it to my boyfriend, saying, 'This is what the doctor has prescribed for me'. He will give me that money.

The doctor went on to tell me how women often invoke hospital visits as a pretext to obtain money from their partners – money that is subsequently spent on completely different things. Whether used as a pretext or not, for some women prenatal visits are at least an important topic of negotiation vis-à-vis the genitor of the pregnancy – who, if he wants to assert his paternity, should take financial responsibilities. In a setting where reproduction is uncertain and contested, biomedical services are as much a tool to manage pregnancies as to negotiate social stakes around these pregnancies.

Conclusions: social tensions and solitary tactics

This chapter has explored Gbigbil perceptions and practices surrounding the conception, development, and birthing of babies. It showed that the success of these reproductive happenings is contingent upon several social circumstances. Conception should be supernaturally approved; the 'filling with force' and viability of foetuses depends on the (variable) blood force of both parents as well as a pregnant woman's food intake, emotional reactions and moral behaviour in daily life; and deliveries may become endangered by the actions of others in social and supernatural worlds. In contrast to the explicit focus on the risks *of* (multiple) pregnancies, as verbalized in current international and Cameroonian reproductive health debates (see Chapter 1), local perceptions in East Cameroon stress risks *to* pregnancies and fertility, often coming from relevant social others (see also Adetunji, 1996; Allen, 2002; Chapman, 2003; Feldman-Savelsberg, 1999; Njikam Savage, 1996). Especially within Gbigbil kinship and marriage dynamics, in which fertility is always wanted by some and contested by others, pregnant bodies become vulnerable social objects.

Yet, even if pregnancies are largely *social* affairs in Asung, there is ample room for secret management or discursive manipulation by individual women. The first, hidden, trimester in particular offers women opportunities to decide on the future of potential foetuses. Embryological notions of a gradual and contingent development from a mere 'void' into a 'child' allow for inventive interpretations of what a pregnancy contains and how it should be 'prevented' or 'protected' at a particular moment. Many other notions are liable to tactical application as well. Perceptions of predestination, for instance – informing views on fertility endowment, menstruation, conception, and total number of births – do not inhibit women to either contest these notions through alternative discourses or tactically deploy them to justify their fertility regulation practices. Likewise, biomedical discourses and services are purposively avoided or exploited in the material management of, and social negotiations around, pregnancies; pregnant women are pragmatic patients combining different health care options and opinions.

Thus, in their daily lives, Gbigbil women can either *underline* or try to *undermine* the social character of their pregnancies. The following chapters will build on this insight when exploring what happens when pregnancies do *not* culminate in a live birth but are instead interrupted. The aim is to find out how, when, and why women draw upon 'specific forms of sociality' (Guyer, 2005) and individuality in their navigation of these reproductive conjunctures.

PART II: CONJUNCTURES

3. OLD BODIES AND GREEDY PANTHERS: ON VILLAGE ETHICS OF PRODUCTION AND REPRODUCTION

All those baskets had hollowed out that sharp angle in her back like the notch in some tree stricken to death by the axe. The skin around that place had become as thick as an elephant's. 'Is this my flesh and blood?' her mother had sobbed when Amalia still as flat as putty on the wall began to sulk about carrying the basket of provisions that they had made specially for her. 'Who will want to marry a girl as frail as that?' she went on. 'Who will ask for a girl in marriage when she can't even carry a basket?' (…) 'The whole village is making fun of us', her mother told her. 'Everyone says you aren't a woman… You can't even carry a basket… What will your husband eat?'

- Ferdinand Oyono, '*The old man and the medal*' (1967, p. 55)

***Wife 1**: The daughters of this village don't have any plantations of cocoyam, nor of cassava. They can only pick leaves to sell on the market.*
***Wife 2**: But they don't stay in their marriage for a long time, do they? Their husbands refuse them, because they can only pick leaves. You, daughters of Asung, are refused everywhere.*
***Wife 3**: It is laziness that hampers you all. You can only think of picking leaves, going to the market, and doing niangá [making yourself beautiful].*
***Daughter**: Lazy?! Look at you, how skinny you are [to Wife 3].*
***Wife 2**: You insult her because she is skinny?*
***Daughter**: Well, is she strong then? She has no force.*
***Wife 3:** Even if I sit down, I am busy preparing, selling stuff, or I have people who work for me on my fields. But you, daughters of Asung, you tend to sell everything. You forget that you have a family to feed. Whereas we, wives of Asung, we are 'those who* can*', not 'those who* want to*'.*

- Translated recording of a ritual interaction (*saŋba*) between in-married wives and daughters of Asung during a funeral ceremony in the village (2009)[1]

After having described fertility-related contexts and conceptions in the previous chapters, this part of the dissertation will focus on particular vital conjunctures around fertility interruption. It aims to give detailed descriptions of women's navigation of interrupted reproduction in East Cameroon. The first chapter of this part will present the views and experiences of Gbigbil women whose fertility becomes interrupted when they live in Asung and aim to continue to do so; the next explores the desires and decisions around the pregnancy interruptions that women face when they envisage an urban life and future. The difference between these two chapters is thus not

one between different types of women or reproductive events – for most Gbigbil women move flexibly between rural and urban areas all the time (see also Abega, 2007; Akuri, Weinger, & Barton, 2009) and conceive and lose pregnancies in both realms. Rather, the distinction is an *aspirational* one. The following chapters explore how the particular (rural or urban) aspirations that women (and others around them) hold at certain points and pathways in their lives affect, and are affected by, the situations they encounter in reproductive conjunctures. Situating reproductive navigation within women's wider frames of projects and possibilities allows for an understanding of how reproductive conjunctures affect the pathways that women had embarked upon, and how and why certain 'horizons' into the future are explored or evaded in the process.

This chapter zooms in on moments in women's lives during which rural ambitions are predominant. In trying to unravel what it means to be deprived of (possible) children in the village of Asung, it touches upon various local perceptions, practices, and social arrangements that affect women's rural pathways and the projects they choose to pursue when these pathways become endangered during critical reproductive conjunctures. Of relevance are notions of (interrupted) babyhood, womanhood, wifehood, and motherhood, and their social manifestations and negotiations in the village setting. Ideas about what is lost (a baby or not?) and of who one is after such loss (a woman, a wife, a mother, or not?) define the public opinions and personal options around interrupted fertility. We will see how a central conception of 'force' underlies all of these issues and is essential to understanding the reproductive navigations of women who aspire to rural respectability.

The rather extreme story of Yvette's repeated '*fausse couches*' ('wrong deliveries') will form a starting point to explore these dynamics. Yvette's multiple mishaps shed light on the particular perceptions and practices that may evolve around different reproductive interruptions – which, among others, provide 'fertile' ground for a reflection on the dichotomy between miscarriage and stillbirths that I denounced in the introduction to this dissertation. Further, the repetition of Yvette's interruptions allows us to unravel some more general patterns that underlie women's decisions to change projects when previous pathways to rural respectability seem to derail.

'A story to sleep upright': Yvette's story

Very early on a sunny morning in January 2008, mama Rosie rushes into my room with a pace that is quicker than her heavy body would normally allow for. Visibly wrought between the urge of delivering her message and the carefulness with which she wants to transfer it to me, she informs me that my friend Yvette has finally given birth, but that – as anticipated by us all – her situation is critical and that I should really go and take a look. Fearful of what I will encounter, I cross the road to the maternity ward of the village health centre. My fear proves to be justified; I find a naked Yvette lying in shock, with her

arm pierced by an intravenous device provisionally attached to the window next to her, and her legs positioned upwards on a chair provisionally installed on the delivery table. She is surrounded by an enormous sea of blood and vomit. While the doctor tells me something about a retained placenta, anaemic shock, and the immanence of death, I remain as silent as the two other women who witness this scene – one of them I recognize to be Yvette's mother. I notice how silence also surrounds the package of towels on a table, which I know encloses the newborn baby. Fearfully I inquire about his condition. The doctor affirms that although he was born with the umbilical cord wrapped around his neck and had to be reanimated after delivery, the little boy seems fine for now. But if nothing is done for his mother, she will be the one to lose her life.

As if protesting against this forecast of dying at the age of twenty-nine, Yvette slowly opens her eyes and tries to stretch out her arm to me as soon as she discovers my presence. I take this as a call for attention, closeness, and help; my initial silence suddenly turns into a sense of critical action. My question about the involvement of her husband or family members, whom I find remarkably absent here, is only met by the doctor's scornful laughter. 'They say there is no money and they don't care'. Most of her close relatives turn out to have left for the fields today, as if nothing was happening. It is only with my financial contribution and the doctor's urgent directions that Yvette's husband and family members go and search for appropriate medication in the city a few hours later. The short-term health improvement this induces in Yvette makes them decide to quickly take her home, whereupon Yvette relapses in her mother's kitchen, and is administered with a new intravenous device – this time provisionally attached to the bamboo wall of the dark hut. She finally needs to be transported to an urban medical centre in order to receive three blood transfusions – paid for by her sister-in-law who migrated to France, and who immediately transferred money through Western Union upon hearing the news – before regaining consciousness.

Somehow this dramatic event had been foreseen and feared by Yvette until the moment her labour pains had started. On Christmas Day some weeks earlier, when people outside had been sharing food in a joyful mood, she had come into my room to share her worries with me:

> People gossip a lot about this pregnancy. They say I should not have conceived that quickly after my last delivery. I had to leave sexual relations aside for some time, because I was very ill. Back then, I was about to die and people spent a lot of money to save my life. It was catastrophic and it has spoilt everything. People started to gossip when I got pregnant again. Many say that I will only die. But they don't want to spend money on me anymore. Until today, my family-in-law has decided that the day I will be in labour, they will go to the fields. If I will die, they will only hear the news of my death when they will return from the fields. So they won't participate with even 100 francs [0.15 Euro cents] anymore. Yesterday, my mother-in-law thought that I was in labour when I sat silently in the hangar. She took me aside and told me, 'Really, if you start [feeling labour pains] now, you should go to the hospital alone. And if I will be in my bed at that moment, don't even try to knock on my door. Go to the hospital alone. If you die, they will send the message to your husband, and he will go and carry his baggage'. This is what she told me. Erica, will I give birth or will I die that day?

> It is only God who knows. But if I deliver and survive, this will give a lot of shame to my mother and my family-in-law.

Despite the critical circumstances, Yvette finally survives this eighth delivery. Her in-laws, who eventually *do* spend the money they were initially unwilling to waste on her, seem not ashamed but rather quite satisfied with the situation, now that their daughter-in-law has survived and a new son has been added to the family. But not long after Yvette's return from the hospital, the weak and fragile baby boy – whom I named after my father when I was given the honour of giving him a name – refuses to drink his mother's breast milk. Wondering whether her milk is too poor after her heavy blood loss, or whether it is the effect of the milk of the many different women who have nursed the child during her stay in the hospital, Yvette resorts to her paternal relatives in another village to search for indigenous treatment – both for her own health and that of her baby. When I visit her there, she happily shows me the black cords attached to the child's limbs, which will help him to gain weight and increase force. She relates how the concoctions that she drank have also already induced a new flow of 'clean' milk; her hope for health has thus been restored now. However, on the day Yvette's husband Daniel comes to pay a visit to his wife and newborn son, my father's namesake dies. Yvette tells:

> The story of my son's death is a long story. No signs, no dreams. I played with him at 2 pm and one hour later, he was dead. My husband had come to see how we were and to give some products. I needed new baby powder and body lotion. After I had been playing with my baby, I wanted to breastfeed him but he refused. He wanted to cry but uttered no sounds. People told me to take him to an old woman who knows many remedies. I carried my child and asked her to look at him. She said, 'Leave it. The child is already dead'. I didn't want to believe it. My aunt deceived me by proposing to go to another woman who might be able to treat the child. But everybody knew the child was already dead. They went ahead, I followed them. While passing the homestead, I suddenly saw how women warmed up water in the kitchen. I asked why they did so. Finally they admitted, 'Yvette, we can't hide it from you: your child has been dead for a long time'. I swear to you, Erica, I don't know anything. It is only God who knows why this happened. My family-in-law doesn't stop insulting me, but I suspect my co-wife of having done this. What a coincidence that my child dies exactly on the day my husband paid me a visit. Is it my co-wife who sent my husband to kill the child? I don't know. But all the insults make me want to leave the marriage. I suffer.

This death triggers much upheaval, in which both Yvette and her in-laws constantly reconceptualize the marriage between her and Daniel. For Yvette, the priority now is to prevent any further catastrophic deliveries, and therefore to resort to reliable, modern contraceptives and to refuse intercourse altogether. She even considers leaving the marriage; without a sexual relationship or emotional and financial support from her husband and in-laws, what is left to stay for? Her family-in-law, in turn, discusses what Yvette is still worth keeping for. Having spent a lot of money on her, without any visible results other than problems – with five of the eight children born in this marriage having died, with Yvette's current refusal to bear any more children, and with her continuous quarrels with husband and co-wife – they decide that no bride-price payments should be

transferred to Yvette's family. 'They have concluded that my hospital costs cover my bride-price', Yvette relates in astonishment. It leaves her mother and paternal family members furious and the future of her marriage unsure. As during her last pregnancy, I find Yvette several times throwing her kitchen utensils outside as a sign of determination to leave her husband – only to be discouraged by her sisters-in-law, convincing her that, after all, her own family can not give the support and financial security she finds within this marriage.

This dramatic direction was not at all expected by Yvette when, some fourteen years ago, at the age of fifteen, she had chosen for this marriage with Daniel against the wishes of her mother. Having already borne a son with Honoré, whom she had met at school and whom her mother appreciated as 'respectful and well-mannered', she had caused serious problems when refusing to marry him:

> That love had started at school in Bélabo. Every night, he came to visit me. I cooked, he ate. You know the behaviour of young girls here: I worked a lot, I cleaned the house, I washed everything. And his mother had seen how I moved about. She came to ask my mother if she could accept that her son would marry me. So these were relations between two *mamas*. Well, and pregnancy is something that you might take without knowing that it is this or that night that you conceived. You only know afterwards. The child had come like that, accidentally in the night. It was an accident; it was not a marriage. Even if his parents brought everything that traditions demanded during my pregnancy, internally my heart was not with him. My mother wanted him because he often gave her presents and a lot of respect. But I refused. And in the end, it was up to me to decide. She didn't even have the right to speak. And my grandmother protected me.

After delivering her first son in her maternal grandmother's house in Asung, and having internally refused the marriage with Honoré, Yvette purposefully prolonged her stay in the village until her baby walked and could be weaned. It was during this period that she met Daniel, the son of the chief of the Bibakung family, who made her pregnant and was eager to marry her as a second wife – thus freeing her from the prospect of a forced future with Honoré. Yvette gladly accepted; her mother was furious. It remains contested whether this fury was aroused because of the material and symbolic profits which Yvette's mother received from the urban student and not from the village dweller Daniel – as she herself lamented when I asked her about her opposition; or because – as Yvette reasons – there was a line of kinship between the two lovers since their respective grandmothers had come from the same family; or because – as others say – Yvette's mother had a secret affair with Daniel's father and did not want this relationship to be interrupted or made public. Whatever her specific motivation, Yvette's mother had opposed the 'love marriage' between her daughter and Daniel to such an extent that the first daughter borne to consolidate this marriage was nicknamed *Mekoppo* – meaning 'problems' in the Ewondo language.

Despite the difficulties caused by the opposition of her mother, Yvette remembers the beginning of the marriage with Daniel as one characterized by 'love and attention'.

Daniel, eager to convince his angry mother-in-law of his worth, did his best to fulfil his financial obligations during Yvette's pregnancy and after the birth of *Mekoppo*. Even the initial relationships with her family-in-law and Daniel's first wife were described as 'very good' by Yvette – especially after another son was born and 'the field started to produce as well'. Although her mother disturbed the peace from time to time, Yvette remembers having been supported by all other people surrounding her; she was happy to have persisted in her choice for this seemingly fruitful marriage. But then she started to bear children who all died quickly after birth. It drastically changed her position in, as well as her reflection on, her marriage and the wider village:

> Disorder came only when I started to bear children who died. It brought a lot of problems in my marriage. His family talked. They asked themselves what my benefit is if I only bear children in order to bury them. Every time it is like this: I get pregnant, I deliver, and the child dies. My first son who died did not cry when he was born. Everybody told my husband, 'Don't buy any clothes, this is not a baby, he will die'. He made movements, but no sounds. He had no force. It is the jaundice I had in my belly that caused this. It tires the child out. Maybe that is why all my children die. I am suffering from jaundice during my pregnancies. Well, for this child, I could also say that they mystically killed him. Because the delivery was very difficult. I delivered the boy in the house of my brother. Well, and the midwife in the house of my brother...you know that when a woman is feeling labour pains here in the village, she cannot say directly that she is in labour. So my labour had first lasted for several hours before I called upon that midwife. I only went to see her when the water announcing the arrival of the child had already come out. She told me that I would deliver soon. But that wasn't the case at all! A lot of problems, a lot of blood that flowed. She started to say that since the child was stuck, I must be a witch. That it was my witchcraft that kept the child in my belly. Another midwife was called for extra help. They now started to say that it was my co-wife who had administered some remedies when she had suspected I was in labour. She had blocked my delivery. I was already very tired when I finally delivered the child, but the child lived. And for three weeks, the child lived well. But during one night, when we were asleep, an owl [considered as 'the bird of witchcraft'] started to talk on the roof of my brother's house. The next morning, the child didn't drink my milk anymore. I thought, 'Shit. How can I lose my child within this state of suffering where people insult me that it is my witchcraft that held my child in my belly? What can I do? I don't know anything'. We left the house of my brother and searched for remedies. But my child lost a lot of weight and died. I don't know exactly what it was. I only know they killed my child mystically.
>
> And then, you know, marriage here in the village...People told my husband, 'Your wife is still very young. If you leave her to wander around now, and if she plays with another man, her childbearing will flee far away. You should play with your wife so that she will quickly conceive again and remains fertile'. So after the funeral, my husband told me to sleep with him. A new pregnancy entered, not even three weeks after the death of my son. The twins I delivered also died. For them, people said it was caused by jaundice. Because they have come out prematurely. I had delivered them after eight months, whereas I should have given birth only at ten or eleven months. Then, they could have survived. Others tell me that this premature delivery had been caused by my falling on the field with my baggage, when heavy rain and wind had made me close my eyes. People gave reasons like that. Well, and when I gave birth, the one child died immediately and the other stayed. Nevertheless, we wanted to adhere to the traditions of the village [i.e. after the birth of twins]. For six days, I had to eat special leaves without salt and pepper since I was *niaŋa mīvīyaa* [mother of twins]. My house was not swept. And the placenta was placed on the cooking fire. After six days, people would then clean my house and wash me traditionally in the river. But my mother-in-law started screaming that she didn't like the affair of traditions anymore. That we had to

> take the child to the missionaries so that the priest would put his hand on the child's head. She took the child to the Sunday Mass. When she returned, we only saw how the child left [i.e. died]. Without any illness. Because they had already done these traditions with him, these things of witchcraft. Why would you then still take the child to the church? Monday morning arrived with the little corpse exposed in the hangar.

Next to all the possible external causes which Yvette relates with regard to her sons' deaths, in the eyes of others she had also become suspect herself. In a later conversation, she confided to me how her in-laws had started to accuse her of eating her own children like a greedy panther – in the world of witchcraft, that is. The deaths of three of her co-wife's children, which happened more or less simultaneously, induced a whole range of witchcraft accusations and counter-accusations between the co-wives. Although Yvette had considered 'searching' for the causes of the deaths of her children, she had concluded this to be too costly an option – both financially and socially. Not only was she unable to find the money – or a person willing to contribute financially – to pay the price which *marabouts* would charge for their clairvoyance sessions. But also, and more importantly, those healers would most likely indicate the cause to be '*à côté*' – that is, a maleficent person in one's own family or family-in-law. Dubious accusations would then upset Yvette's social relations that had already become precarious, as the initially 'very good' conjugal atmosphere had gradually turned into one of suspicion and hostility.

Within this context, Yvette started to search for means to prevent another pregnancy. With the help of some elder women, she used several indigenous methods: burying her menstrual blood in a snail shell under her cooking fire, throwing it away on her fields while asking the ancestors not to send her another pregnancy, sending a bottle filled with delivery blood into quickly streaming water, carrying a preventive cord around her waist, and drinking *nivaquine*® pills or salty water after every intercourse with Daniel. Nothing helped; she bore another daughter, who stayed alive, and conceived again for the seventh time after she weaned her *məŋaa* – as the daughter following twins is called. Although Yvette initially wanted to get rid of this pregnancy, considering the hostile environment and the increasing negligence of her husband, it was her ignorance of abortion methods, the unwillingness of other women to share this knowledge with her, and especially her fear of death resulting from abortion that made her accept the fact that she was in the end 'a married woman and supposed to bear children'.

Ironically, however, her seventh delivery turned out to be one in which bearing children became intrinsically related to that same fear of death:

> I was here at home, with all my labour pains. And mama Julie [the co-wife of her mother-in-law, acting as a birth attendant in the family] had already taught me how to insert my hand during labour. I myself touch and feel whether the child is far away or near. So when I go to her, she knows that the child is already that close that she will only have to catch it. But this seventh delivery, I don't know what happened. The child couldn't come out. So rather than that the child gave me the force to push, I had to push by myself, with my own force. It didn't work; I was already too tired. At five o'clock in the morning, my sister-in-law came in and asked, 'How is it? Why are you staying like this until five o'clock so that the whole village

knows already that Yvette is in this state? You should take her to the hospital. What will you do in case an accident arrives? She should die in the hospital, not here. And anyway, you should not kill somebody else's daughter. Yvette has come here to bear children. If people practice witchcraft on her now, I want them to turn their witchcraft on her husband, because it is he who took her into marriage'.[2]

Mama Julie called for help from another midwife, who has torn my vagina all the way to the anus. Wanting to force my delivery, it is these village women who have killed my child. At the moment my child died in my belly, I lost my head. I screamed, 'I only see darkness now. I don't see any people anymore'. I was rolling in my own vomit. I don't know how they got to transport me to the Provincial Hospital in Bertoua. It is only when the child had already come out there, and the doctors were sewing my wounds which the women had caused by tearing my vagina, that I felt an enormous pain, opened my eyes, and screamed out loud. It is only then that I saw my dead baby lying on the table. The doctors saw my torn anus and said that they wanted to send the midwives to prison, since they nearly killed me with their village witchcraft. But it is my father-in-law who barred this plan. You know he is a *sous-chef*, he knows politics. So the women stayed. My urines and excrements flowed out of my body in disorder. I was crawling like a child, couldn't walk upright anymore. I suffered a lot, and the wounds down there even started to rot. Every day women put pepper in my vagina, to heal the wounds. It was a good remedy, but it hurt badly!

Now people started to talk about me, even more than before. Because they had spent a lot of money on me. And when you have already given money to save the situation of a person, even if you talk, I should not respond to you. What can I do? If I respond, I am foolish. Because you have helped me. Even if you insult me, I should not speak up. I am in the water like a plate that doesn't move. If you come to move the water, I stay. If you pour the water, I stay. If you store the water, I stay. If you wash your hands in it, I only look at you. My life is like that at the moment. But I am not dead, I am alive. Here I am; and I don't know anything about witchcraft.

The gossip and negative comments also affected Yvette's co-wife Suzie. The indirect accusations of witchcraft uttered by Yvette's sister-in-law were interpreted by Suzie as explicitly directed against her. Her subsequent denials of any complicity ironically raised suspicion amongst her in-laws, who initially had not interpreted the general warning as one against Suzie. The escalation of the situation finally led to the departure of Suzie to her own family. Suzie herself tells:

When Yvette wanted to die during her delivery, it caused me problems, because they said it was me who had blocked her delivery. My family came to take me home. We went to make use of remedies we call *mesot*.[3] To see the truth. If I was cause of this, the remedies would work on me. I would leave [i.e. die]. But if I was innocent, the remedies would turn to the other side. Every time a leaf falls down, it means one head should fall. It would start with the children in the family, but would in the end take everybody, even the chickens. And it didn't work out on us. The remedies found that we were innocent. So it was Yvette herself who must have known something in her belly [i.e. Yvette must be a witch]. If Yvette's paternal family had not come to supply, which they did even with a goat, they would be finished by now. All of them would have died. Because they had accused me and I didn't know anything. My family asked, 'Why would I kill, whereas my own children also die? Why wouldn't they accuse my co-wife of killing my children as well?' But people didn't want to listen, they only said it was me. I stayed for more than a year with my own family.

Suzie's remarks show how the affair started to involve not only the two co-wives, but also their respective families. Unfortunately so for Yvette, for exactly in the year in which her

co-wife left, she was not only faced with the loss of her stillborn baby, but also with the death of her maternal grandmother, who had always served as a mother for her. Her own mother, having left the marriage with Yvette's father when her two children were still very young, had taken Yvette and her younger brother to her own maternal family in Asung. This is where the two children spent most of their youth, while their own mother went back and forth between different marriages. Yvette's grandmother, herself also having settled down in her own family after several failed marriages, was described by Yvette and many others as 'a woman who worked like a man'. The enormous revenues gained from her work in the fields made her a safe haven for Yvette and all other children and grandchildren, who had centred around their vital grandmother. Her death was an enormous loss for Yvette, who, still suffering from her last delivery, no longer knew where to find help; her relationship with her own mother had always been problematic, her father had disappeared to Douala on the other side of Cameroon, both parents had very few direct siblings to resort to, and her only younger brother was constantly ill. Although the latter – probably influenced by the loss of their affluent grandmother, his own nearing death, and the life-threatening delivery of his sister – had tried to demand some bride-price payments from Yvette's in-laws, he was sent away by his sister's father-in-law, who again exerted 'his politics'. Yvette's position within her husband's family had become precarious. She felt physically vulnerable, and, with the loss of central figures around her and the prospects of a bride-price, also socially deprived.

In the midst of this turmoil, Yvette conceived for the eighth time – the pregnancy with which this story started. Only seven months after her 'near miss' experience, from which she was still recovering, this pregnancy ran counter to all indications of both doctors and village *mamas*. Faced with immense public indignation and condemnation, Yvette sadly defended herself by saying:

> Men are the way they are. What can I do? Do I live with my brother? I was with my husband. And he is the one who did all this. There is a distinction here in the village. When a woman gives birth, holds her baby in her arms and nurses him, she is different from the one who has given birth and the child has left. You see? For her whose child has left, it will not even take five months before she gets pregnant again. She will give birth when the child of the other maybe just starts to walk. There is a big difference, but people don't want to talk about that. They only want to sabotage the other who gives birth a lot. But if you go into marriage and you *don't* give birth, it is also *kongossa* [gossip] that surrounds you. So I don't know how the village wants women to be.

Despite Yvette's transfer of all responsibility to Daniel, most villagers blamed Yvette herself for her irresponsible sexual behaviour. Yvette, they told me, had neglected her own health just to make her husband love her instead of her co-wife, who was about to re-enter the house – a sexual flaw inspired by lust and jealousy denoted by the Gbigbil word *ágon*. Others interpreted her quick conception as a proof of some greedy occult power in her belly that was still searching to offer new foetuses to 'the other world'. This hypothesis was given extra force by the accusations of her co-wife Suzie, who,

immediately upon coming back into marriage, had lost her 4 year old daughter. Yet others more sorrowfully commented upon Yvette's particular body shape – a combination of a short body size with pronounced buttocks designated as *bənt* – which must have deformed her birth canal, called *ndjol akuka* in its misshapen form. Whatever the explanations given, everybody agreed that Yvette's next delivery would become critical. Not only would her body have to prove whether it was able to shed so much blood again, but the delivery would also imply a critical test for Yvette to prove her innocence in witchcraft matters, and for her family and in-laws to prove their commitment to their daughter(-in-law). Indeed, on that sunny morning in January when all our eyes were fearfully turned towards a heavily bleeding Yvette and some seemingly indifferent bystanders, much more was at stake than Yvette's life or that of her baby.

These stakes become even clearer to me one year later, when I return to the village for another fieldwork period. Curious whether I will find Yvette still in the marriage that she so seriously threatened to leave one year ago, I am happy to find her with her three children in the same kitchen – this time with all the utensils inside. Dedicated as she now is to her work in the fields, I often accompany her to help her sow beans or harvest maize. Looking back on her childbearing experiences, she says:

> If I hadn't encountered my current situation, I would have loved to continue childbearing. I always desired to have many children, because I am all alone in the belly of my mother. And my only brother will probably die soon as well. So my children have become my little brothers and sisters. Yes, I always wanted to give birth, but the devil didn't want that.[4] And you should not insist on something that doesn't hold. If I die during childbirth, I won't take any person with me: not my husband, nor my children. I will die all alone. So they can tell me anything, but I want my health first. Look, all these deliveries made me like an old woman. I was never maintained after birth like is usual in the village: massages with warm water, body lotions, hospital injections, and good food. These all wash your stomach and skin and give you new force. But my husband even refuses to give money for soap or body lotion. He says I have eaten [*boufffé*] too much of his money already. And lack of maintenance makes women old. I lost a lot of blood and thus a lot of weight. It had to be recuperated all. With the blood I received in the hospital I had become very fat! But now I have to work hard again because these two years of illness had made my fields overgrown and unproductive; I had to recommence from zero. I have become like a child, although I spent so many years in marriage. Nothing is left, so I should work hard now. At the same time, I can't exhaust myself too much; my body is still too weak. I work a bit in the fields and go home. There, I don't eat well. My husband refuses to give me any money but my field doesn't produce yet. So automatically, I lose weight. I am still a little girl but I am already old and skinny and my skin is ugly. Women of my age call me 'old mama'. You see?
>
> So in turn, I refuse to continue childbearing now. In the past, I got pregnant blindly, and that's what took me into death already. But now I take the pill and it works well. And the affair of staying with my husband during the night doesn't interest me anymore. I block him. It is just because I am married that I sometimes have to allow him. I know I'm not living with my brother. And it is good to be married; if something happens to me now, people will search for him. Sleeping together or not, but I am with him. He will have to take care of me. But apart from that, here in the village, the marriages that people talk about, there is nothing in it except for suffering. It is only good if you produce children and work hard on your field. Then, you are a person. If you don't work in the fields, there can't be a marriage. So for me, it is really important to sacrifice myself to my field now. In order to ensure the future of those

> children who stayed. I stay in my marriage to take care of my children. I can't leave them behind like my mother did once to us. I don't want the same suffering for my children. I suffered as a child, I suffer here in marriage, and my life will always end in suffering. The bride-price, he has never given, but I gave him many children. I am dying, because I have to be married, but I don't see any marriage here.
>
> And since I don't even have any kin, any family to support me... On both paternal and maternal sides, there is nobody who can tell me, 'Come, I will take care of you'. If I had such a person, I would not even be here anymore. But now, if I would leave, where will I stay? Who will take care of me? Everybody is dead. So I prefer to suffer and to look after my children. And I also will have to take care of the three children of my brother when he dies. Erica, can I walk with them like a pig searching for food in the dustbins? I have a heavy charge now. I need to have a field so that I know that even if I go to stay [with my paternal family] I leave some maize behind for them. And I would also want to leave them with an inheritance. You see? For, to take them with me is no option. To still find another marriage with these children behind me, that would not be easy huh? No, I am in a marriage and I will stay. What can I do? It's the village. Because if you're not married, you're not with a person, everybody will come to bother you and present himself to you. Especially since I am still a small girl. And if you refuse people then, they might bring along their witchcraft or send you a bad fate [i.e. mystical illness]. It's dangerous. But going into a new marriage is also dangerous for me. It will be always the same thing: the man will first want to have intercourse in order to give me a pregnancy. No, that's not possible anymore. I only want my health.

Luckily her health tends to improve during this last fieldwork period – unlike that of her brother. With an enormously swollen belly, he is taken by Yvette to several healers in neighbouring villages, but dies in the end. His death turns Yvette's apparent resignation with regard to her conjugal situation upside down; she loses in her brother not only the most likely negotiator with regard to an eventual bride-price, but also one of the few safe havens in case her marriage would end. Secret hopes for either a stable marriage or a stable shelter outside of marriage suddenly disappear. Further, Daniel's refusal to fulfil his ritual obligations as son-in-law of the bereaved family – e.g., by financially contributing to the coffin, buying linen to wrap the corpse in, or digging his brother-in-law's grave – triggers a new wave of contestation of the value of Yvette's marriage with him. During a family gathering, Yvette's paternal relatives – angry about Daniel's financial irresponsibility – decide to set an ultimatum for a first bride-price transaction. Daniel's argument that Yvette's hospital costs cover more than the bride-price is heavily disagreed upon by his in-laws; even if Yvette would have died in childbirth and would have been buried on their ground, they would still have demanded the customary 'corpse's bride-price' (*ivoula mīm*) to recompense Yvette's many lost years of childbearing and conjugal suffering. If nothing is paid by the end of the year, her paternal uncle will take her home. Whether the uncle's words will be transformed into deeds remains unsure; his relationship with the children of his brother has become highly ambiguous since the latter's disappearance to the city. Interpreting this departure as an irresponsible preference for lazy city life over hard working village life, Yvette's uncle once confided to me that he does not see why he should be the one responsible for children like Yvette, raised in another village and never really respecting him as a 'father'. Yvette, however, happily holds to his promise; it frames her life again in terms of hope rather than loss.

With this impetus of hope and courage, Yvette invites me to accompany her to visit the tomb of her last son (my father's namesake) in her father's village. Due to her ambiguous relationship with her paternal uncle, as well as the mournful 'pain in her heart', she had never dared to go back and honour her son since his burial some fourteen months ago – a fear which, with her uncle's recent promises and my assistance, would be easier to overcome. On our way to the village, we meet Yvette's former classmate. Putting his arm around her shoulder, he laughingly tells me, 'My friend here often disappears, and on the day we see her she has a child in her arms. Then she disappears again, and when we see her again she has another pregnancy. We never see her without pregnancy or baby. She is still very young like me but has at least borne eighteen children!' Yvette mockingly responds that eighteen is even too small a bet; she's a mother of at least twenty children.

But this laughing away of what touches the core of her existence soon turns into intense sadness when we approach the house which her brother had constructed in his paternal family's compound before he died – next to which she knows her baby lies buried. The silence with which Yvette explores the four empty rooms in the house is imbued with many meanings and unspoken understandings: the decay of a house which has never been inhabited symbolizes not only the death of her brother, but also the more general absence of a strong supporting paternal family in Yvette's life; not only her brother's forlorn hopes for a stable conjugal future in his family, but also her own vanishing hopes for an alternative safe haven in her unstable conjugal future; and not only the discontinuation of her brother's family line, but also the continuation of her own suffering with her and his children without a caring husband – and, with her last dead baby lying around the corner, the discontinuation of *her husband*'s family line as well. With tears in her eyes, Yvette walks outside, only to find that the tomb of her son has been as much washed away by the rain as the walls in her brother's house have been eaten away by termites. The tears she initially tried to control wet her cheeks when she stands right on top of the place where her last child, and last hope, must have been buried one year ago. Walking to an empty hangar a few meters ahead, and sadly looking at the only photo of her son that I had made last year, Yvette breaks the silence by saying, 'The story of this child is a long story, Erica. It was a child of suffering. A child of *kongossa.* A child of sabotage. A child about whom people could even write a song. A song without an end. This is a story to even sleep upright. Where and how will it end?'

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Although without a clear end, Yvette's story of repeated child deaths can be a start for an in-depth exploration of the experiences and implications of reproductive interruptions for women in rural East Cameroon, especially those who envisage a future in the village. It

offers insights into local meanings of babyhood, womanhood, wifehood, and motherhood, and the ways in which these meanings are mobilized in the navigation of reproductive conjunctures. The following sections will unravel the interplay between such social norms and notions on the one hand[5], and individual explorations of particular projects on the other. They will present different aspects of daily life and discourse in Asung that will eventually help us to understand Yvette's management of her ambiguous ambitions and precarious pathway to rural respectability in the face of repeated child deaths. By first exploring existing notions of interrupted babyhood, the next section will continue where the previous chapter ended: at the vulnerable beginnings of life once a Gbigbil baby is born, and the development of physical life force and the expected life course afterwards.

Foetal futures: developing bodies and predestined personhood

A birth, a cry
A pain, a noise,
Still very tender, friend
A heart that beats with life
(...)
This force that springs from its fragility
Doesn't stop astonishing me

Henri Dikongué - 'C'est la vie'

Although probably not a song which could be sung about Yvette's last son, these lyrics expressing the awe of the Cameroonian singer Henri Dikongué at the birth of his first child *do* touch on ideas of the tenderness, fragility, and sprouting life force of newborn babies that Yvette would also be able to relate to. As noted in the previous chapter, Gbigbil people consider newborn babies (*tiəŋli mon*) as extremely vulnerable. This fragility is first of all believed to be *physical*. The gradual transformation of 'water and blood' into a lizard-like creature and then a 'child' (*mon*) is only the start of what people consider a lifelong development of body substance and physical life force. Although newborn babies show all human forms and body parts upon birth, they are considered extremely weak and 'tender' (*tekaa*). Their delicate bodies are believed to be wet and to contain only 'water water' – the same expression as is used to denote a beginning pregnancy, indicating that it is just the flaccid beginning of something that could assume a more firm state later on. The veins of babies are filled with plenty of 'fresh' and 'clean' blood (*mekil kpamak*). This body moisture results in a certain physical 'looseness' denoted by the onomatopoeia *idəng dəng* – an expression which also indicates the flabbiness of bloody organs extracted from hunted animals, and which was translated by one informant as 'something slippery without bones to move with force'. Indeed, the bodies of young babies still need to be filled with 'hard bones' (*biveey*) and force (*ngul*); the

process of 'filling' the body that started during pregnancy continues after birth. These internal developments are often accompanied by transformations of the outer skin, as mama Rosie explains:

> The skin of a newborn baby is still very tender (*iko nyol agin tekaa*). When the umbilical cord falls down and the navel dries up, the skin becomes a bit harder and its colour also changes. From three months onwards, children can sit by themselves and are not carried around in towels anymore. From this time onwards you can say *asó mon*: it is already a child. After that, the child will start to crawl, which again hardens his skin. He takes the form of a developing person now. As long as the child drinks his mother's milk we call him *aginne momon:* it is still a little child. But when he is weaned, it is really a *mon.* His skin also becomes like the skin of a real real man.

Healthy physical development is accompanied by a gain in weight. Maternal breast milk is deemed essential in this respect; it offers vitamins and contributes to the development of bones and blood – and thereby, physical force – in the baby. A refusal to drink maternal milk is perceived to be caused by either 'spoilt' maternal milk, or by the baby's ill-health. It is a sign of heightened vulnerability and nearing death – an immediate interpretation that also pervaded Yvette's worries when both her first and last son stopped drinking her milk. Many natural remedies exist that are believed to induce the production or 'cleaning' of maternal milk, and thereby enhance the solidification and the reduction of physical vulnerability of a child. Despite her efforts to take these remedies, Yvette initially suspected the death of her last child to have been caused by her lack of breast milk resulting from a period of maternal depletion and heavy blood loss. Without blood – and thus, milk – in the mother's body, a child's body cannot gain blood, weight, and force either; it remains skinny, vulnerable, and exposed to death. Not surprisingly, the most adored babies in the village are the plumpest ones, representing health, force, and resistance.

Next to this physical frailty, the beginning of life is also characterized by *spiritual* vulnerability. Especially right after birth and in the first years of life, before they can talk with humans, infants and small children are believed to remain in contact with the supernatural realm from where they came – called *ayong bekon* (the realm of the dead) or *ayong Zambe* (the realm of God). They communicate and play with the dead. Mama Denise recounts how her grandson Stéphane had once scared her:

> When I was working in the fields, Stéphane was playing. He suddenly started to mention names and babbled something like, 'Come, come and play with me'. When he did that, I was scared. He played and he laughed, he laughed, he laughed. All alone! He was so engaged, that you would say that there were at least two or three of them. When I called him and told him to come to me, he approached me but his eyes were only behind [i.e. he looked behind]. I immediately returned to the village with him. When I asked here why Stéphane would do this, villagers told me that Stéphane has people to play with. But it is only Stéphane who can see them, I can't.

This spiritual link also makes young children knowledgeable of upcoming deaths in the village; many mothers recount how their babies had cried unstoppably during the days and nights just before someone in their neighbourhood died. Several remedies – such as black coal rubbed on babies' faces in order to ward off bad spirits and to 'see only black darkness' – exist to make children less vulnerable to spiritual influences. Infants lose this connection with the supernatural world only gradually. The longer they live, the more their 'human' life course takes over (see also Gottlieb, 2004; Molel Belika, 2008).[6]

Conceptualizations of the unfolding of the human life course are pervaded by a sense of predestination; the future of every person is somehow already 'written' at the moment of birth. Thus, children can be born to grow up as thieves or to become ministers – with the latter constituting an often expressed wish of Gbigbil mothers. Generally, the older a child gets, the more people see of 'the kind of person' he or she is to become. Once a child starts to play, talk, and listen to orders, his or her personhood, talents, and possible future paths are gradually felt and considered. But even before that time, destiny is at work; indeed, it is in terms of spiritual predestination that the whims and woes of the fragile beginnings and endings of life are often explained.

First, it can be exactly a person's *fate* to be born and to die immediately. Sometimes God wants his children back almost immediately after birth. 'We don't know how many children God will send to us and how many he will take back' is an often heard reason for bearing many children. God may have several reasons to reclaim his children. At the funeral of a seven month old boy, a priest wondered in his sermon whether any family members in the preceding four generations had committed some sin that resulted in 'God saying that the child who shall be born will die'. Something must have been done wrong in the family of the little boy, because 'if God had wanted it, you would have discovered the illness before it got worse'. A person's destiny is thus not merely individually conceptualized, but dependent on (the actions of) social others, now and in the past.

Second, the opposite may also be true; a child can be born and granted a great future by God, but it is exactly these wonderful prospects that are seen and destroyed by the devil. Driven by their envy, witches may wish to destroy or spoil a child for whom a successful destination is 'seen' lying ahead. They often attain this goal through transmitting their witchcraft to the newborn baby before the umbilical cord has not fallen off.[7] They may also send 'a bad fate' (*le mauvais sort*) or other illnesses – biomedical or indigenous, general or specific 'children's diseases' – that prove fatal in young babies with little physical resistance or force.

Third, a child's spiritual connections might also influence the development of the beginning life course. Sometimes a child is called by a dead relative, as was explained by a woman I spoke to just after the burial of Michelline, who had died with an ectopic pregnancy, leaving her two year old daughter behind:

> My child has been very ill in his early years. His father died when my child was twelve months old. Afterwards, I had a lot of problems with him. He suffered from the illness of the fish [an indigenous children's disease]. I told myself that it must be his father who wanted to take him. That is often the case, especially with young children of that age. If somebody dies who loved the child very much, he can take away this child. Unless he is treated with remedies, the child will die as well. But if he is protected by remedies, the dead person will smell them and will not be able to approach the child. This is also the case for the daughter of Michelline whom we buried now. She was her mother's only and much beloved child. Haven't you seen how she couldn't stop crying during the funeral? We often say that the child can still see her mother. Now we should treat her with remedies, so that, if Michelline will come to get her child, she will smell them and go away.

Other babies might choose by themselves to 'come to show their face only' or to 'come in order to return immediately'. People seemed to allude to this kind of volatility when they said that Yvette's first dying baby was 'not a baby' and not worthy of buying clothes for since he would die anyway. Babies may have several reasons to 'leave' immediately after birth: some foresee their own predestined, meager future with their current parents and 'flee' back to their safe haven; others might be angry or insulted about something people said about them – which is an important reason to be wary of excessive praising of newborn babies; and yet others come just to 'tease' their parents from time to time. Such babies come and go; they die and are born again. Stories abound in the village about children having been born several times. In order to detect these deceitful children, people bury them with a clear physical mark – formerly a cut finger or toe, but nowadays just some incisions on the cheeks or elsewhere on the body – which will be easily traced on future babies. These 'reborn' babies will be called 'rotten' (*bebole*), 'earth' (*metəkki*), or 'hoe' (*ibakh*) – names that refer to the burial of the child who preceded them. Similar conceptions of rebirth are described by Einarsdóttir (2000), Gottlieb (2004), and Gupta (2002) for Guinea-Bissau, Ivory Coast, and other parts of the world respectively. In the East of Cameroon, these repeatedly returning children are often called 'Mont Kupe', which is in fact a mountain in the South-West Province of the country – perceived as the place where spirits reside.[8] Mama Georgette explains the births and management of these children as follows:

> Mont Kupe children come to search for wealth here, because they are poor over there. The person is born naked, isn't it? But when he dies, he will be buried with cloths, coffins, and toys. All these things, he takes with him to where he came from. Well, if we suspect children to come and go like this, we put marks on their faces. We don't want this kind of children here. Because they come to disturb people. You know, especially in our days, the layette might even cost fifty thousand or sixty thousand francs [75 or 90 Euros]. You spend your money and then you lose your child. That's painful. So if that happens repeatedly, we put some marks on the child. You will recognize him next time. When such a child has come back and gets ill, you should only send him bad words. You shouldn't protect him! It is a child that you should blame all the time. 'If you have come to search for my wealth, you will really return like you have come to earth: naked and without anything. Aka! If you cry or you are ill, I just throw you away, I don't care! Tomorrow or the day after, I will still conceive another pregnancy. If you want to leave, you just leave! It is not the first time that you come here. I

> know you. Look at the marks that they gave to you!' It is this kind of bad mouth that you must give to your child. So that he will not leave anymore.

Due to these multiple connections with and influences of invisible forces, infants are vulnerable beings who linger in a space between the realm of the living and the realm of the dead. Neither completely belonging to the one nor the other, the life course of babies is surrounded by much uncertainty. As Mary Douglas (1966) theorized a long time ago about people without clear identifiable positions in society, the status of Gbigbil newborn children is ambiguous – pervaded by both vulnerability and potential danger. Their social instability is reinforced by their physical frailty and lack of force to resist bad influences (see also Aboubakar, 2008, p. 62).

At the same time, the idea of predestination does not preclude a certain subjectivity and agency of babies and young children – like those opting to go back to where they came from if they encounter disappointing conditions (Gottlieb, 2004; Gupta, 2002; Kaufman & Morgan, 2005; Scheper-Hughes, 1992). Nor does it imply the absence of explicit management and protection of newborns by their parents. For, even if they are sometimes threatened with words as explained by mama Georgette above, most babies are carefully protected through confinement, washings, and cords, as well as by biomedical substances and pharmaceuticals (see also Hardon, 1987).[9] Especially women like Yvette, who have been confronted with child death(s) before, are eager to visit 'old mamas' with healing knowledge or to experiment with herbs themselves. Many treatments exist for various vulnerabilities and possible afflictions; if unsuccessful, infant deaths can be attributed to many different specific causes and threats. As seen in Yvette's story, the multiple explanations for the deaths of her sons range from illnesses such as jaundice or weak breast milk, to several forms of witchcraft attacks, and the contestation of Catholic protective interventions. These causes are often – but not necessarily – different from the causes of loss *before* birth, to be discussed in the next chapter. But at the same time, and almost paradoxically, despite their particularities, child deaths and other reproductive interruptions can become veiled in a public cover of similarity and indistinction. The next section will delve into Gbigbil perceptions of the relationships and differences between various sorts of reproductive interruptions, both before and after birth. As these perceptions affect the experiences and navigation of critical reproductive moments, the rest of the chapter will then continue to explore why certain interpretations were preferred over others in the specific case of Yvette, and how this accounts for the particular pathways and projects she preferred during her different reproductive conjunctures.

Falling pregnancies and forceless babies: reproductive interruptions reconsidered

When talking about reproductive interruptions, Gbigbil women distinguish between the interruption of a *pregnancy* (*abum*), where no clear human being is formed, and the loss of a *child* (*mon*), presenting human forms. The previous chapter described how the first months of a pregnancy are not only invisible on the outside, but are also considered 'void' on the inside. At most, people speak of 'water water', 'blood', or a lizard-like creature – all covered by the term *zəng mon*. A loss that happens at this moment is usually called *abum ia song.* In my efforts to unravel the literal meaning of the verb '*song*' – which was often simply translated as 'leaving' or 'aborting' – I was provided with an insightful metaphor by a male Gbigbil student:

> *Song* can be comprehended as the movement of a falling cup. Imagine that the cup contains something inside – water, for instance. At the moment it falls down, it turns upside down and the water flows. You can then say, '*kop ia me song a mo*' ['the cup falls out of my hand']. This is similar to what can happen to a pregnancy. In fact, conception of a pregnancy resembles the idea of the cup. A beginning pregnancy contains water water. Only by turning it upside down the water can flow. So *abum ia song* indicates this capsizing movement of the fall of a pregnancy, in which the child has not yet been formed.

Tellingly, you do not 'lose' a pregnancy; your pregnancy can be 'falling' (*abum ia song*), 'coming out' (*abum ia so*), 'leaving' (*abum ia vawa*), or, in more general terms, it can be 'wasted' (*abum ia diggela*). The specific workings of this 'fall' at the initial stages of gestation are, again metaphorically, explained by Sophie through the expression '*abum ia bugiye*':

> We use the word *bugiye* when you break something partially. If you break a pen, for instance, the inner part remains, the outer part falls down. The same happens during pregnancy. The small foetus that develops inside is surrounded by blood. So when it does *bugiye*, this surrounding blood breaks off and falls down. The inside remains, but cannot stay for long by lack of blood and will come out afterwards. So when the blood flows and the foetus is still inside, we can say, '*mekil me bugiye abum*' ('the blood breaks down from my belly/pregnancy').

Sophie specifies that this process can only take place when the developing foetus is still surrounded by its constituting blood – which reminds us of the distinction between *zəng mon*, a non-human embryo developing inside a ball of blood, and *mon*, a foetus with distinctive human forms, as described in the previous chapter. Once the watery substance of *zəng mon* has given way to something more firm and human-like (*mon*), the pregnancy itself is also said to be 'hard' ('*abum iso detaa*'); it can no longer fall or break. Denotations of pregnancy interruption change accordingly; the expulsion of the foetus is now phrased in terms of the delivery of a dead child. Common expressions relate that 'the child has passed' ('*mon ia nul*'), 'the child is dead in the belly' ('*mon ia wa abum*'), 'she has given birth to a child who is dead' ('*abiali mon ia wa*'), or simply 'the child has died'

(‘*mon awali*’). Most of these expressions are also used to denote perinatal and neonatal losses or even infant and child deaths after birth; indeed, while these biomedical terms are based on strict temporal divisions (and on notions of viability, which are also time-related), for Gbigbil women it is not so much time in itself which underlies the various forms of loss and viability of children.

Although Gbigbil women distinguish the interruption of a pregnancy containing *zəng mon* from the loss of a visibly human creature called *mon,* the exact dividing line between the two is fluid and contested. Since *zəng mon*’s development into *mon* is variable and contingent upon the amount and quality of the blood – and therefore, force - – of both parents, the difference between losing a ‘pregnancy’ and losing a ‘child’ can not be traced to fixed linear time patterns. Rather, what matters are the forms and force (*zəng*) *mon* displays upon expulsion. Only if human features are clearly discernable does it concern the loss of a ‘child’. And since there is no conceptual distinction between a completely formed *mon* inside and a baby outside the uterus, its decease *always* concerns the loss of a formed child embodying the potential of life (force) – whether that happens before, during, or after delivery.

Tellingly, biomedical temporal divisions between early and late stillbirth, perinatal death, and early and late neonatal death all dissolve into the Gbigbil use of the word ‘*fausse couche*’. Although this French term is formally translated into ‘miscarriage’ in its biomedical sense and thus meant to be associated with the first few months of gestation, my Gbigbil informants use it as a synonym for ‘*faux accouchement*’ (‘wrong delivery’) which can only happen after a *mon* had been created out of a *zəng mon* in the later stage of a pregnancy. Indeed, once a *mon* exists, its expulsion is automatically termed a delivery – whatever the gestational age. ‘Wrong deliveries’ thus encompass all cases of reproductive interruption where contingent circumstances make it impossible for a *mon* to continue to live. These circumstances might first of all be related to a fatal ‘prematurity’ of *mon* being delivered ‘before his time’ and *not* able to survive it – the flipside of the success stories mentioned in the previous chapter. This is what Dorine tries to make clear in one of my first interviews exploring the meanings of the term *fausse couche* – a notion which I heard in many cases where I, with my time-based assumptions, did not expect to encounter it:

> *Me*: When can you call something a *fausse couche*?
> *Dorine*: Here, we talk about a *fausse couche* when you are over time for four or five months, for instance. You go to the field and you put your cassava, plantains, nuts, and bananas in your basin. You put it on your head and walk away. If you fall with this baggage, you might have a *fausse couche*: the child will leave.
> *Me*: During which phase of a pregnancy can a *fausse couche* happen?
> *Dorine*: It doesn’t have to do with time. If you should deliver tomorrow, but you have an accident today where you fall very badly and your child leaves, we call it a *fausse couche*.
> *Me*: From which month onwards?
> *Dorine*: It is not dependent on the month. Even if you have a pregnancy of nine months or ten months and you have had a bad accident, the child will leave. All this, we call a *fausse couche.*

Despite my insistence on pinpointing a time interval, Dorine's insistence on coming back to the example of the accident is insightful; it highlights how all births which happen 'accidentally' – that is, before the appropriate moment of birth, which only the foetus knows – are considered 'wrong deliveries' if they end dramatically. 'Wrong deliveries' can occur at all moments in time, exactly because they are not dependent on time in its *exact* sense. At most, they represent bad *relative* timing, with the discrepancy between the actual birth and the envisaged birth being too substantial to allow for survival. This contingency of 'wrong deliveries' reappears in Elianne's answer to my (time-based) question of whether a six month old foetus would be able to live:

> No, I'm not sure. Some women give birth at eight and a half months, others at ten months, others at nine months. In short, it depends on the duration… whether your child takes a long time to develop or not. Sometimes you deliver at eight months and your baby is able-bodied [*bien portant*]. Like when I delivered my second daughter at eight months and three days. I thought she would be a *fausse couche*, since my first boy had lasted for eleven months! So when my daughter came out at eight months and three days, I believed I had a *fausse couche*. But it was a normal delivery. I now know that girls don't take as long as boys do. My son could never have survived a delivery at eight months!

Next to being related to incomplete internal developments of *mon*, 'wrong deliveries' may also result from outer negative forces such as witchcraft and illnesses, attacking the vulnerability of *all* babies – inside and outside the uterus. Many women noted that even a child who is born seemingly healthy but dies within a few hours or days due to external causes, can still be called a *fausse couche.* 'You didn't deliver normally, did you? The child has passed anyway', would be the rhetorical answer to my initial confusion. In the same vein, the different losses of Yvette which might be termed perinatal, early, and late neonatal deaths in biomedical terms, were all called 'wrong deliveries' (*fausse couches*) in French or 'passing children' (*bon ia nul*) in Gbigbil; what counts is that all the babies that had developed in her belly finally 'passed by' – whatever the specific moment and cause of these losses. Thus, rather than their specific differences, it was their common consequences that were stressed: potential lives had left, and left Yvette's life without potential.

This is not to say that these losses are not *experienced* differently by mothers. Many women indicate a great difference between the loss of a *mon* that is still in the uterus and the decease of a *mon* that one has seen with one's eyes, and whose human traces, forces, and destiny had already become discernable. They express their experiences mostly in terms of visibility of the child's humanness – its forms and force. Thus, the expulsion of an indiscernible *zəng mon* is often minimized since it does not yet show any human features. Likewise, the loss of a *mon* who died 'before its time' is coped with rather easily since, even if the baby already looks like a human being, its dead and forceless body is immediately taken out of sight and buried without much publicity.[10] But the death of children who have been born well formed and full of force, and who have been cared for and given a name, is heavily lamented and remembered.

Despite the discourse of continuity surrounding *mon* – and, therefore, the indistinction between *fausse couches* – different and often contradictory meanings of *mon* do thus exist. The variety of these ideas, which co-exist with notions of contingent (pre)maturity and viability, as described in the previous chapter, allows for a whole array of possible reactions to and interpretations of reproductive interruptions, as well as of justifications for the choices made afterwards. Fluid, ambiguous, and contested boundaries between the interruption of a 'pregnancy' and the loss of a 'child' during the initial stages of pregnancy leave some room for women to strategically appoint what is actually lost – mere 'blood' or a 'child'. Different interruptions happening at similar gestational stages may be defined as a 'wasted pregnancy' in one case and as a 'child loss' in the other; alternately and paradoxically, both labels can also be applied to one and the same instance of loss. With regard to interruptions at a more advanced gestational stage, the particular differences between losses of 'children-to-be' may be explicitly stressed at one moment, while they disappear under the veil of similarity and indistinction at others. This flexibility provides women with a possibility to either downplay or attract attention to their reproductive interruptions within the given circumstances and contestations surrounding their pregnancies; it offers a rich terrain for negotiation of the beginnings and endings of human life (Kaufman & Morgan, 2005). More than a fixed temporal framework, Gbigbil person-dependent and flexible embryology allows for person-dependent and flexible interpretations of reproductive interruptions.

It is interesting to explore when and why one interpretation comes to the fore and others are suppressed, and how this creates or obstructs certain pathways and projects in the reproductive conjunctures that women navigate. Later on, I will explore how, why, and by whom Yvette's particular reproductive trajectory came to be described as a row of 'passing children', a repetition of similar *fausse couches*. I will point out how these ideas create a certain social image that deeply affected Yvette's ambitions and options. Yet, at the same time, we will see how such a unitary view is countered by Yvette's own ideas of clear differences on a physical level. Indeed, one area in which differences between reproductive interruptions are unanimously stressed is the domain of their *physical* experiences and consequences. These dynamics will be discussed in the following section, which moves from the realm of the baby to the realm of the mother.

Diminishing force: fields, fire, and fertility

The foregoing has shown the vulnerabilities and possibilities of interruption in the early years of life. Although still called *bongo tekaa* (tender children) until far into childhood, over time children are considered to gradually solidify with the intake of breast milk and, afterwards, nutritious food. They can thus be increasingly exposed to external influences, heavy movements, and some occasional beating – deemed essential for a proper education. Within this education, children are constantly evaluated on the basis of the

force that they are able to display. While small children are encouraged to walk around with small cups or plates on their heads, from the age of six or seven 'they should carry baggage and show how strong they are'. Like in the epigraph at the beginning of this chapter, girls in this Gbigbil village are especially challenged to prove their strength by carrying heavy yields on their heads after work in the fields. This challenge is often vigorously taken up by girls themselves; more than once, I noticed some unease in mothers when their daughters insisted on carrying a package of field products or wood that almost equalled their own body weight. The physical vulnerability with which children start their lives thus gradually turns into a zealous display of *in*vulnerability, force, and resistance. Although much of this attitude is supposed to be a result of education, ultimately one's strength is grounded in one's blood, as is made clear by mama Georgette:

> If you see a woman who walks tired tired, with hanging arms and unable to lift her feet normally, you know that she is a lazy woman. She is so weak. But if you see a woman who acts like a man, yes! You know that she is very strong! Solid! It is the blood that is behind all this. So you can't force to be strong if your blood is not strong. You can't. It's your creation. And you will always remain like that.

This quote expresses an admiration of strong women, successful and respected by everybody.[11] In this village where women's daily lives centre around work in the fields, it is not surprising that those who work hardest and produce most are the most wanted and respected. As women are held responsible for the production and preparation of food, as well as many other heavy household chores, one of the most important criteria for men in selecting their wives concerns their physical strength and solidity. Women themselves, in turn, are often proud to claim their ability to 'endure suffering' (see further Chapter 5). But while the display of force and strength might guarantee the social status of 'woman' and 'wife', it also depletes the total amount of force the body possesses. The force that is accumulated over the years through nutritious food intake will gradually diminish and induce processes of ageing and degeneration. Mama Rosie, who bore only one son and remained subsequently infertile, sums up several factors of depletion:

> During your life, your force diminishes firstly because of all the work: working in the fields, in the sun, carrying heavy baggage, searching for wood, preparing meals. You become worn out. But also all illnesses that are in your body diminish your force. You don't eat well anymore, your mouth has become bitter. Also when you give birth, you lose your force. Your body diminishes and you lose weight. And furthermore, you continue to nurse your baby during two years. After weaning the child you carry another pregnancy. You lose your force in all these cases. And the more pregnancies a woman carries, the more blood she loses. Her blood becomes weak. So there is a visible difference between one woman who has borne one child in her life and a second one who gave birth a lot. The first woman is able-bodied [*bien portante*]; the second woman is tired, has lost a lot of weight, and has become dry dry. She has no force left.

Mama Rosie's reasoning reiterates the afore-mentioned link between force (*ngul*) and blood. A body's force reservoir is directly depleted through flows of blood and breast milk during delivery and nursing (see also the previous chapter). But heavy work and illness can also reduce one's amount of *ngul*. In this respect, many women complained that 'the field never ends, but it is your body that ends', and that their illnesses 'finish the body'. The fire on which meals are prepared may have the same effect, as explained by mama Georgette:

> Fire makes the blood black. The blood of women who prepare beignets every day will diminish because of the heat of the fire. And our fire is brutal. Like the sun. We work every day in the sun. These two things warm up the blood. The blood is hot inside. It diminishes and blackens.[12]

Over a life-time, blood turns from 'proper', 'light', and 'fresh' (*mekil kpamak*) into 'dirty', 'black', 'heavy', 'tired', 'weak', or 'full of diseases' (*mekil vinda ne mekong*). Due to this lack of force in the blood towards the end of life, old people's bodies are again called *tekaa,* which, in contrast to its sense of tenderness with regard to young children, takes on the meaning of 'worn out'. Many people point to the similarities between old people and babies: both are weak and low in force. But there are differences in appearance, wetness, and skin texture; while the bodies of newborn babies are perceived to be wet and tender, ready to begin a process of hardening and solidification, at the end of life the skin is thought to have become 'hard' and 'dried up' (*kotaa*) – and the body devoid of blood and force.

This outer degeneration of the skin, which is directly related to the depletion of inner force, can only be combated by intense maintenance (*entretien*) of the body surfaces. Body lotions are deemed the best remedies in this respect. Many were the women who, after excessively praising my white skin for its tenderness, would ask me for the creams and ointments they assumed I must be using. They repeatedly regretted their lack of body lotions and the unwillingness of their husbands to provide them with these products. In fact, with the depletion of life force and ageing of the body reinforced by their duties in marriage – working in the fields, preparing food on hot fire, and, most of all, bearing and breastfeeding children – the complaints about neglected skin formed an idiom to express both one's commitment to marriage obligations and one's frustration about not getting anything in return from the husband. Conflicts about body lotions are therefore at the centre of negotiations of conjugal responsibilities. For instance, in her reaction to Yvette's attempts to leave her marriage out of anger over her husband's negligence, Frédérique lamented:

> That's what always happens to me as well! I have borne a lot of children, but have never been maintained after deliveries. Even after my stillbirth, I just remained like this! No hospital care, no injections, no pills. Negligence. My husband doesn't give me money and doesn't care. He even neglects giving me oils and creams! That's why you see my body as worn out as you see it now.

Although the presence of, and parallels between, women's agricultural, culinary, and childbearing pursuits in marriage have been noted for many other locales in Cameroon as well (Feldman-Savelsberg, 1996; Goheen, 1993; Houseman, 1988; Johnson-Hanks, 2007; Laburthe-Tolra, 1981; Notermans, 1999), the bodily idioms around them have been left unmentioned. Some of these studies rather highlight the *symbolic* link between field, fire, and fertility; they agree with Houseman's argument (1988, pp. 51-52) that 'a woman's cultural transformation of raw food through cooking in earthenware containers is at once metaphorically associated with her 'cooking' of the foetus in her womb during gestation, and metonymically associated with her cultivation of the earth itself through gardening'. Others instead focus on the gendered *power* dynamics underlying 'women's control of the resources which [a]re essential to their perceptions of what would be feminine, that is, food, earth, and children' (Goheen, 1993, p. 254). None of these studies mention the perceived *physical* effects of such productive and reproductive marriage duties, or how these in turn affect women's sense of womanhood and wifehood – while exactly these issues resonated most in my informants' complaints of their marriages and village lives. The extremities which women encounter in rural fields, by the fire-side, and through fertility quicken the ageing process.

This is especially the case with extreme deliveries and pregnancy interruptions. During reproductive mishaps, women lose more force than during normal deliveries (discussed in the previous chapter). Many informants distinguish between early and late pregnancy interruptions to explain the different ways in which force is reduced. In case a pregnancy 'falls' in the initial phase of development, a lot of blood is lost: not only the blood of which *zəng mon* is constituted, but also all the surrounding blood which aims to protect and nourish the foetus. Here, the abundance of blood loss *directly* causes an enormous depletion of a body's reservoir of force.[13] This happens *indirectly* with difficult births in which the child to be born is weak or dead. A mother's loss of force is then inherently related to the decreased force of the baby. A child who is delivered 'before his time' does not have the appropriate amount of force to initiate and manage childbirth by himself. Such a child becomes 'tired' very quickly, drowns in the surrounding water, or simply dies from fatigue, and leaves it to his mother to finalize the delivery with her own force. In cases where the child has already died *in utero*, this effect is even aggravated; with no incentive from the dead foetus at all, the delivery demands an enormous amount of a mother's force. This happened during Yvette's dramatic seventh delivery, when she fainted due to a lack of force after the child got stuck in the birth canal and died in the process. Something similar occurred when my informant Michelle delivered a stillbirth with the help of a traditional birth attendant after a long and painful labour:

> The child was near, but he didn't want to get out. They forced to get the child out, but it was very difficult. It took too long. Since the child was already dead, he could not get out by himself. So they had to push my belly, so that the child would at least take the right direction. The head of the child came out, but his feet stayed inside. She [the TBA] again inserted her hand and hooked her fingers to pull the child out. At least, that's what people tell me, since I,

> I was already… I don't know. I was already tired, I could not even scream anymore. I was already… it was not even what they call fatigue huh? I was already dead.[14]

Both 'wasted pregnancies' and 'wrong deliveries', then, are intensely feared by women. Charlotte describes the exact details of, and differences between, the two incidents as follows:

> *Charlotte*: If your child dies in your belly, the delivery is more difficult than for the child who comes alive. When you are pregnant and you want to deliver, the child that is in your belly gives you the force to push. You see? But it is difficult to get a dead child out if you don't use your own force.
> *Me*: And what about the loss of a pregnancy where the child was not yet formed?
> *Charlotte*: Anyway, it is the same. Because the child who is not yet formed will also be unable to give you the breath to push. It is alike to the child who died in your belly and who leaves without giving you force. But an early abortion is more painful than whatever delivery. Because it is torn from your own body. The pregnancy was not yet mature. A child wanted to develop, but its development is cut in the middle. So something removes the egg of the child with force! So it should hurt a lot. And you lose a lot of blood. Both before the foetus leaves and afterwards. Some women even faint. They have no blood left. No force in their bodies anymore.

Not surprisingly, the expression 'abortion is worse than childbirth' ('*l'avortement dépasse l'accouchement*') that my informants often invoked is explained in terms of the loss of blood and force for both mother and child. Therefore, even more than after normal childbirth, blood replenishment is deemed necessary after reproductive interruptions; women make abundant use of indigenous remedies and feel a more urgent need for biomedical injections in order to recover quickly. Yet, even if women fear interrupted pregnancies most for the enormous *immediate* physical depletion they cause, their *long-term* effects are supposed to be less traumatic than the effects of repeated nine month gestation and two year nursing periods for women bearing living children. Those who continuously feed a foetus with their blood and nourish an infant with their milk lose more force in the long term than those who experience one short but intense attack on their reservoir of force and blood. The reproductive life trajectory of those who conceive a new pregnancy while they are still nursing their previous one (*abial tute*), or immediately after its weaning (*abial ikut ikut*), is especially one of gradual but constant degeneration. Thus, while in other cultural settings childbirth and breastfeeding are considered 'time out', offering a possibility for rest (Dykes, 2009), Gbigbil women stress the physical toll these constant losses of blood, milk, and force demand.

Similar conceptions have been described for rural Gambian women by Bledsoe (2002). Rather than time being the essence of ageing, she argues that 'pace and character of senescence are contingent on cumulative wearing events such as reproduction that erode life's sustaining forces, with harsh experiences causing disproportionate loss' (ibid., p. 322). Since women in the Gambia 'view the anatomical and energy limitations on the body as more important than a menopausal end to reproductivity', Bledsoe argues that the length of fecund time is 'a function of how well a woman takes care of her body'

(ibid., pp. 323-324). Preoccupied with the maintenance of blood levels, force reservoirs, and skin texture, Gbigbil women are as much 'active shapers of their biological destinies' (ibid., p. 325) as their Gambian counterparts – despite their afore-mentioned ideas of a predestined life course. Predestination and management go hand in hand, exactly because the unfolding of the life course and life force are believed to be *contingent*. Blood and body always become weak over the reproductive life span – with pregnancies taking longer to develop and deliveries becoming increasingly painful – but the pace of degeneration can be influenced by individual management and social support. While Bledsoe considers such contingencies only within the context of conjugal life – a limitation of her study exposed by Hunt (2005, p. 425) – the meanings and management of Gbibgil force levels should be situated within wider social worlds as well.

Yvette's case sheds more light upon the relationships between contingency, individual management, and social support (or the lack thereof) *within* and *beyond* the conjugal frame. By delving into these particularities, the next section will try to make sense of her reproductive navigation. It aims to unravel the individual ambitions and social stakes that affected Yvette's pathway to rural respectability as well as the projects that she envisaged when this pathway became endangered by repeated child deaths. Furthermore, it will outline how these pathways and projects are related to the afore-mentioned notions of (interrupted) babyhood, womanhood, wifehood, and motherhood.

Ambiguous ambitions: Yvette's experiences reconsidered

As described above, the roles and statuses of Gbigbil village girls and women are dependent on the amount of force they display; it serves as an indicator of their worth as (future) wives whose main responsibilities are to work in the fields, to prepare food, and to bear children. Especially in this setting where married women come from 'outside' – another village or another lineage in the same village – and therefore occupy an ambiguous position surrounded by suspicion and hostility, there is a clear interest for them to display their physical capacity to fulfil all expected duties. Accomplishments in the domains of 'field, fire, and fertility' thus become morally laden, determining who is considered a *good* woman, wife, and mother. I therefore speak of the 'ethics of production and reproduction' – a notion inspired by Paxson's (2004) discussion of different 'ethics of womanhood' in modern Greece.[15] In her study on changing ideals and practices of motherhood in Greece, Paxson sees gender as an ethical 'system of virtues', prescribing 'what it takes to be good (at being) women or men' (ibid., p. 11). She shows how these ethics fundamentally underlie women's sense of self – even affecting what they perceive as their innate 'nature'. However, rather than a biological destiny, this 'nature' should be considered a metaphysical category 'in that it requires the social actualization of certain virtues and relationships realized first in practice and second in the public recognition of that practice' (ibid., p. 13). That is, only by displaying socially

acknowledged virtues can a woman reveal her embodied womanhood, thereby proven to be *good* womanhood. Gender thus becomes a 'matter of moral responsibility' (ibid., p. 13). In modern times that offer a multiplicity of 'ethics of womanhood', this continuous process of achievement of good womanhood has become one in which women negotiate, combine, and contest different moral responsibilities at the same time.

Yvette's story shows similar dynamics. Over her life course, the ethics of production and reproduction were explicitly discussed and reconsidered by the different parties involved. For Yvette, her initial years of marriage were characterized by her own conformity to social expectations and conjugal duties; the conception of several pregnancies of which the outcomes were successful and her hard work in the fields contributed to the rise of her status as a strong, zealous, and committed daughter-in-law. This conformity to the ethics of production and reproduction opened up a pathway towards respected womanhood, wifehood, and motherhood in a marriage that was, like all new marriages, precarious. What prevails in Yvette's descriptions of this period is an imagery of force, autonomy, and multiplicity of possibilities. That some of this force would necessarily be lost in the process was taken for granted; the ageing effects of marital duties were implicitly accepted as part of a woman's life. In fact, as Bledsoe also stated for Gambian women, 'by shaping her aging process on behalf of a certain man and his family, a woman can build a moral reputation and establish her conjugal security. Indeed, since the efforts that age her are seen as helping to build her husband's family, the number of children she has produced may well matter less than how she has conducted the process of aging itself' (2002, pp. 24-25).

It is this *process* of ageing that went awry after Yvette's fourth birth. The physical toll of constantly carrying and birthing babies without any long-lived result or any period of bodily 'rest' and 'maintenance' was exacerbated when Yvette's last two deliveries became extremely traumatic in themselves. For Yvette, this was where the *real* problems started. Far from being considered a normal and expected effect of life, this *excessive* ageing and bodily neglect now became explicitly questioned and regretted as an extraordinary sacrifice she was making for her husband and in-laws – without getting any rewards in return. Her complaints about ageing and weakness thus form an idiom with which to stress her own *virtuous* and *responsible* womanhood, wifehood, and motherhood, while at the same time allowing her to comment upon the *vicious* and *irresponsible* attitude of her husband and his kin. What is at stake in these physical complaints and comments therefore seems intrinsically *social* in this rural setting where women's bodies and their life force directly inform their (re)productive statuses.

This seems even more the case since Yvette uttered these complaints in a situation where both her *wider* social network had collapsed and her social status as a woman, wife, and mother was challenged by others. Regarded in this light, her idiom of weakness comments upon her reduced social status that has, paradoxically, become comparable to that of a weak 'child' (with the Gbigbil word 'weakness' (*tekaa*) denoting

not only old age, but also fragile childhood). While excessive *physical* tolls had made her grow old, she had become a child again in a *social* sense. Just like for newborn babies and infants, whose ambiguous status in the world of human beings was described before, Yvette's status and embedding in existing social networks had become precarious. And since it was unlikely that she would be able to fulfil the ethics of production and reproduction in the foreseeable future, her re-entrance into childhood seemed almost irreversible – symbolized by the constant overgrowth of her formerly productive field, the last tangible proof of her earlier respected womanhood. With these equations to a small child or an old *mama*, little was left of the imagery of force, autonomy, and multiplicity of possibilities with which Yvette had depicted herself before. Instead, it was a *lack* of force, independence, and opportunities – verbalized in expressions like 'I should not speak up' or 'I am in the water like a plate that doesn't move' – that accompanied her lack of productive and reproductive potential.

While Yvette attributed this 'weakness' to the absence of support from her own family and the absence of responsibility in her family-in-law, the latter considered Yvette's excessive ageing caused by her *own* (sexual and reproductive) irresponsibility. The trust that Yvette had succeeded in creating by her initial childbearing and zealous work in the fields gradually turned into distrust of this 'outsider' in whom a greedy panther must be hidden – mystically devouring the much wanted descendants of the lineage. While her first three losses had already aroused some suspicion but could somehow be explained otherwise[16], the two traumatic deliveries – possible indicators of a 'complicated belly' full of witchcraft – turned all attention to Yvette herself.[17] Now that not only her children had died, but also her deliveries had become increasingly complicated, Yvette's previous losses were all reinterpreted as mystical deaths: this greedy panther must have been behind the deaths of her children all the time. Thus, in striking contrast to Yvette's focus on the *discontinuity* and *differences* between physical experiences, outsiders came to frame her reproductive interruptions in terms of the *similarity* of the underlying social mechanisms. Even those who expressed doubts about the witchcraft hypothesis would agree that what *was* sure was that Yvette's 'wrong deliveries' had all deprived Daniel's patrilineage of its descendants – irrespective of how long these children lived and how and why they had died.

That it was Yvette's status and not so much those of her lost children which came to dominate the commentaries underscores the fragility and ambiguity of the position of Gbigbil married women, as well as its dependence on fertility success. Indeed, that Yvette's reproductive interruptions triggered a wave of suspicion that had until then remained largely unexpressed shows how this ambiguity towards wives as 'outsiders' is in fact omnipresent and always prone to erupt. Since descendants are so much at stake for the patrilineage, but are at the same time only to be obtained through outsiders to the lineage, it is these outsiders who easily become targeted and blamed for the loss of children. While Yvette's particular child deaths might have been lamented in themselves,

taken together they formed a much stronger catalyst to question, redefine, and negotiate her womanhood, wifehood, and motherhood. With bride-price constituting *the* symbolic acknowledgement of a wife's status and contribution to the lineage, it is not surprising that the discussion came to centre upon *this* issue, rather than the lost babies in themselves. Indeed, these reproductive interruptions had come to be framed within an argument *for* or *against* bride-price transactions. While Yvette, and later also her paternal uncle, would bring up past bodily 'sacrifices' as a justification for its transfer, it is exactly these extraordinary sacrifices that had cast her in-laws' doubt on Yvette's status as a wife and mother – and thus, the right to a bride-price.

Taking into account the inherently ambiguous status of *all* married women in this village, as well as the frequent disregard for marital obligations as described in Chapter 1, Yvette's conjugal situation is not so different from those of many other Gbigbil women. Indeed, both marital frictions and the absence of a bride-price are not at all uncommon in Asung, nor are they restricted to unions where children are lacking or have died. The marital setting is generally pervaded by flexibility; if frictions accumulate or bride-price negotiations fail, unions easily dissolve. Many are the women who, after marital 'neglect' or child deaths, try their luck elsewhere – in another rural marriage, or in an urban setting. The question is why Yvette did not. Why did she decide to stay in this marriage, and let her case end up as extreme as has been described above? If Bledsoe is right that 'each reproductive event will have unique effects on an individual's life, and the effects of all these events, in tandem with her social situation, will shape her future options' (2002, p. 327), then what can be said about the particularities of Yvette's life and the future options these created?[18]

To begin with, Yvette had always occupied a rather particular position in Asung, which was not the home base of her father, nor the village of her mother's patrilineage, but the residence of her maternal grandmother. This situation is rather uncommon as daughters of *multiple* generations have settled in their own family here.[19] The ambiguity and hostility which normally surrounds a *mo kal* (child of the sister) in the patrilineage of his or her mother can therefore be expected to have been aggravated in the case of Yvette and all other matrilateral grandchildren.[20] They seemed protected, however, by their respected grandmother. Yet, with the death of Yvette's grandmother, and later also the decease of her brother, Yvette had lost her protective havens and strong negotiators in case of familial and marital problems. Of the three daughters that her grandmother had left behind, one was married in another village, the other was considered to be crazy, and Yvette's mother had never fulfilled her maternal duties. Few *bengweej* (maternal uncles) remained in the neighbourhood where Yvette had grown up – and those who did were only indirectly related to Yvette's grandmother and mother, thus upholding the ambivalences that normally characterize relationships between *bengweej* and their *mo kal.* More than ever, Yvette had become an 'outsider' in her own village; not only as a contested wife in marriage, but also as unprotected child of *mo kal* in the neighbourhood

of her mother's maternal uncles. In addition, while her network of maternal kin was hampered by death, Yvette's paternal family was gradually emptied due to urban migration. The only direct uncle who remained in the village was openly critical of the departure of his brothers, as well as the burden of the children they left him with. The social distance he expressed towards Yvette and her brother was exacerbated by their physical distance; no substantive support was thus to be expected from the paternal side either.

Apart from an extremely impoverished social body, Yvette also lacked other forms of capital that could have offered alternative pathways. Her first pregnancy with Honoré had put an end to her then still starting secondary school career; the resulting lack of a proper education did not allow for formal training or employment that could help her move away from the 'field, fire-side, and fertility duties'. To leave for a nearby city and search for an informal job or engage in petty trade would at least require some contacts facilitating housing and job orientation, which she did not really have. And her physical state, Yvette lamented, would not allow her to move away from the village anyway. With no options beyond the village level, Yvette understood that, in order to stay there somehow respectfully, she would need to be married; 'What can I do? It's the village'. Indeed, as Guyer (1984, p. 74) has also noted:

> The whole cultural tradition favours being a wife over being a daughter or sister. All the incentives in the rural areas converge to encourage women to aspire to marriage and to remain married. Security of access to land, assurance of an inheritance of one's children and status among the women of the village depend on being married. At the village level, bridewealth payment is still the means of acquiring these rights.

Though these bridewealth payments were out of the question in this marriage as long as Yvette was unable to regain productive and reproductive potential, to resort to *another* marriage was not an attractive option either. Even *if* somebody would be willing to marry this 'old woman with an old body' – which Yvette deemed unlikely – she would again have to meet the ethics of production and reproduction in order to establish herself as a daughter-in-law. That scenario could possibly prove fatal and was thus discarded as an imagined future pathway. With Daniel, at least, she had arranged for an agreement of birth control, and she was excused for her lesser productivity on her fields now that she had lost an enormous amount of life force for her family-in-law. And to be married with a Bibakung man like Daniel was not too bad, after all, for of all lineages in Asung, Bibakung is the most expanded and influential one. The few brick houses in the village are located in this particular neighbourhood; the big plantations of the village are owned by Bibakung men; most of the elites who have successfully installed themselves in big cities or even abroad – such as Yvette's sister-in-law who financially contributed to the blood transfusions – are descendants of this lineage; and the village chief himself is so too. Without a decent network of social support, Yvette seemed not unwilling to claim her dependency on this family. The Bibakung themselves clearly felt less dependent on

Yvette, however. Their relative status, the enormous number of descendants of Yvette's father-in-law (who had married four wives), and their knowledge of Yvette's vulnerable situation not only made them less reliant than other families on their daughter-in-law's services, but also gave them considerable room for exertion of their own 'politics'.

This is not to say that Yvette did not also constantly redefine her personal stakes and ambitions. Even if she had a relatively disadvantaged social position and restricted room to manoeuvre, she *did* rethink her marriage and future after each reproductive or conjugal crisis, or in one and the same conversation with me. Her considerations were often contradictory – at times rejecting the union, at times praising it. They show first of all how vital conjunctures are always full of uncertainties, indeterminacies, explorations, and dismissals of horizons. But they also reveal the *ambiguity* of her personal ambition to stay in a marriage without being able to properly fulfil the ethics of production and reproduction – thus adding to the ambiguity that inheres *any* marriage. In her deliberations, Yvette resorts to various tactical interpretations and portrayals which enable her not only to 'cope with events that do not accord with (…) ideals' but also to 'manipulate circumstances behind the scrim of public scrutiny without upsetting the dominant ideological order' (Paxson, 2004, pp. 94-95).

In her redefinitions of marriage and the concomitant ethics of production and reproduction, Yvette gradually replaced the valuation of successful fertility by a focus on hard work in the fields and friendly sharing of food with in-laws and villagers. Sexuality and childbearing, once the cornerstone of marriage, were increasingly recast as moral matters rather than unconditional conjugal duties. Indeed, given the heavy critiques of her sexual relationships and reproductive itinerary, Yvette's recourse to birth control pills after her last child's death should not just be seen as a means to physical 'rest', but also as a morally laden act – a way to establish herself as a responsible woman and mother. For, as Johnson-Hanks (2007, p. 645) has also observed in the region, 'in contrast to many well-known honour systems, a Cameroonian woman's honour is not merely a reflection of that of her husband or lineage but is something that she claims herself. (…) Sexuality and sexual self-mastery also play important roles in claims to honour; (…) it is wisely managed restraint, good judgment, and self-dominion that matter'. Only reinterpreting the ethics of reproduction in such a way would justify Yvette's non-reproductive stay in her marriage and ensure her position on the pathway to rural respectability.[21]

This does not mean that she had discarded the duties of motherhood altogether. To the contrary, her repeated wish to care for her living children and to leave them with an inheritance should be read as another claim to responsible motherhood. Drawing on the widely accepted 'truth' that mothers offer their children the best love, care, and education (*encadrement*), Yvette justifies her motherhood *and* her stay in this marriage. Again, she reformulates marriage in the process; rather than defining it as the formal framework in which women are supposed to bear descendants for their husbands' patriliny, she sees it as the best environment for the practical creation of informal

matrilateral ties and emotional relations between mothers and children. The local patrilineal idiom is thus at times tactically stressed – such as when Yvette demands protection and financial compensation from her husband and in-laws – while at other times it is explicitly countered by alternative discourses and practical realities – when these appear more promising for realizing Yvette's projects. Focusing not on child*bearing* but on child*rearing*, and stressing her hard work in the fields – and the resulting suffering – as the only means to feed and build an inheritance for her children, Yvette alters the ethics of production and reproduction in such a way that her current position becomes meaningful for both herself and others, 'without upsetting the dominant ideological order' (Paxson, 2004, p. 95).

Conclusions: at a loss through loss

This chapter set out to explore the intricacies of reproductive conjunctures happening on, and possibly altering, women's pathways to rural respectability. It has shed light on some general conceptions and specific social tensions that direct the navigation of reproductive interruptions in the village of Asung. The notion of 'force' (*ngul*) appears to be central for understanding the meanings of interrupted fertility and the projects that women envisage after these reproductive happenings. First of all, notions of *foetal* force are indispensible to understand local *definitions* of reproductive interruptions. The contingent 'filling with force' of babies during and after pregnancy leads to a rather fuzzy distinction between 'wasted pregnancies' and 'wrong deliveries' of 'passing children' in case fertility is interrupted, at odds with strict time-based biomedical categories of reproductive interruptions (such as miscarriages, stillbirths, perinatal, and neonatal deaths). Different definitions of interruptions create different options and opinions; meanings of loss are constantly negotiated according to women's personal projects and the stakes of social others.

Second, notions of *female* force (and the loss of it when fertility goes awry) define the *implications* and affect the *navigations* of reproductive interruptions. As force is needed for activities regarding the fields, fire-side, and fertility, which contribute to women's social standing as women, wives, and mothers in the village, the loss of *physical* force in fertility interruptions always has *social* ramifications. Concerns with growing old and weak can thus denote a sense of social degeneration; physical bodies are also social bodies. This, in combination with the particular social situation at hand, affects the projects that become possible and preferred during vital conjunctures. Yvette's case has shown that in the absence of physical force, but also of social support and other forms of capital such as education or employment, interruptions of fertility might interrupt the wider productive and reproductive ambitions, and associated statuses, of rural women. The inability to live up to the ethics of production and reproduction then exacerbates women's ambiguous position as outsiders in the patrilineages of their husbands.

At the same time, this ambiguity offers room to manoeuvre. Even if physical force and social support were lacking, Yvette constantly redefined and negotiated her stakes and ambitions in line with the horizons that she encountered during different reproductive conjunctures. The ethics of production and reproduction, in need of constant achievement and social acknowledgement, are thus subject to contestations, redefinitions, and changes over time – both between generations (as shown in the epigraphs to this chapter) and within the life course of one woman. The next chapter builds on this insight by shifting the area of ambitions altogether; it describes the experiences of motherhood and its interruption at moments in which Gbigbil women opt to abandon the village ethics of production and reproduction in favour of alternative, urban futures and images of womanhood.

4. BIG FISH AND FOETAL BARGAINS: ON URBAN HORIZONS AND FERTILITY BETS

Viviane, it's you who has done this to me
Viviane, it's you who has emptied my pockets
(…)
I have given my car; no, you didn't come
You have even taken my house; no, you didn't come
(…)
Every day she comes to say, 'Give me the sum of money
That I will use during the week'
I give her my money, the next day she comes back again
'Give me again the sum that you gave me;
I owed money to a friend, she has demanded [it], I gave it back
Please, give again'
She cries for money; I get it out, I give [it]

- *Prince Aimé* – 'Viviane' (my translation)

If men tell you they love you, they have already calculated something on you
If men tell you they love you, they have found something to profit from you
Men are like judges: you think he only treats your case, but he treated many other cases before
Men are like tailors: you think he only measures you, but he made many other clothes before

- Gbigbil song, sung to me by mama Rosie

After having explored the reproductive experiences and ambitions of women like Yvette, who aim to fulfil the ethics of production and reproduction within a rural marriage, this chapter will turn to the visions and practices of villagers with other ambitions. It highlights the reproductive aspirations of Gbigbil women who want to move *beyond* the rural framework. In the face of alternative horizons such as schooling, employment, or flexible relationships with rich urban men, their intentions with regard to marriage and motherhood may be different. The meanings of pregnancies and their interruptions vary accordingly. This chapter will explore the dynamics and decisions around reproductive interruptions that happen when women's pathways and projects have turned towards such urban frames of reference. Again, it should be stressed that the difference between this and the previous chapter is an *aspirational* one – and not one based on different kinds of women or reproductive events. The ideas and circumstances

depicted in this chapter are therefore continuous and co-existent with the previous ones, and add to the complexity and variability of Gbigbil women's reproductive experiences.

On the pathways that I describe in this chapter, the meanings of fertility and its interruptions are not only multiple and changeable, but often also utterly contested. I will show how women attempt to manage these contestations through a flexible use of embryological and aetiological notions. The particular fertility-related frictions and women's inventive answers to them shed new light on the second predominant dichotomy that I traced in the literature earlier: the one between *spontaneous* and *induced* pregnancy interruptions. The uncertainty which surrounds questions of intentionality clearly appears in the story of Sophie, with which this chapter starts; it relates her experiences of pregnancy interruption in an urban context where fertility can be both a quest for stability as well as a possible factor of instability.

From worms to witchcraft: Sophie's story

It is mid-February 2008. Together with my informant Sophie, I am sitting on the floor of a small room in the house of a female Islamic healer, who silently watches us while her son Abdullah joins us for translation. Few words are exchanged, two coins are handed over from Sophie to the *marabout*, and the divinatory consultation starts. Immediately, the *marabout* starts posing questions in Fulfulde, translated by Abdullah:

> *Abdullah*: Your husband, did he marry another girl?
> *Sophie*: Hmm-mm [she smiles meaningfully at me, saying, 'You see?'].
> *Abdullah*: Do you have any problems with your husband?
> *Sophie*: Hmm-mm.
> *Abdullah*: You are not with him, are you?
> *Sophie*: Hmm-mm, I am not in his house.
> *Abdullah*: How did that come to be? Why did you leave the house?
> *Sophie*: Well, for the moment it is because I am ill. I came to my family because I am ill.
> *Abdullah*: But your husband asked you to come back, isn't it? And you don't want to go back, do you?
> *Sophie*: Hmm-mm. I am afraid.
> *Abdullah:* Who gave you the medicines for your body?
> *Sophie*: The medicines for my body? I went to the hospital and searched indigenously as well.
> *Abdullah*: What do you want her to do?
> *Sophie*: I would first of all like to *know*, since I am ill... Because when I am staying with my family, I am in a good state as you can see me now. But when I am there, together with my co-wife, I am regularly ill, it is not going well, there are problems; a lot of things.
> *Abdullah*: She says there is a thing that they sent on you and that you have to treat.
> *Sophie*: So… this thing, is this just on me or is it really in the house, the same house?
> *Abdullah*: It is in the house. She says that you should not go back to your husband like this, without making some medicines.
> *Sophie* [to me]: Erica, you see?

Sophie was the first person I met when I arrived in Asung for a second period of fieldwork. While I was anxiously descending from the car that had brought me to my final

destination, she immediately came to greet me and helped me with all the bags. As I looked at her face I experienced probably the same feelings of surprise, discovery, and recognition as she herself must have felt during the above described visit to the *marabout* a couple of months later, where she finally found some explanations for her unclear and lasting health problems. For both of us, this 'aha feeling' was reassuring and frightening at the same time; in my case, seeing Sophie vividly and unexpectedly reminded me of her look-alike sister Celestine, one of my former informants who had died during my two year absence (see her story in the prologue). Happy to see this 'familiar' face and at the same time uneasily confronted with the death of my beloved friend, I embraced Sophie, who would become my neighbour for the next seven months. I soon discovered that she had temporarily come to live with her mother next to my house, as she was ill and claimed to need some rest.

In taking this rest – being not ill enough to be bedridden but not healthy enough to go to the fields – Sophie had ample opportunity to spend her time with me and to share her worries which, according to her, would make her lose even more weight if she did not talk about them. Thus, the quick daily greetings that we exchanged when I passed by in order to go to the fields in the early morning and the casual talks in the hangar when I came back home at the end of the day gradually developed into long conversations about the mystic death of Celestine, lengthy stories about her own past life, confidential discussions about her current problems, and the serious weighing of thoughts when we explored the options in her search for future health and prosperity. Over time, the face that I had initially so much associated with Celestine revealed its own hidden personal story.

During one of my first visits to her mother's house, Sophie smilingly started to tell me about her good memories of her childhood in this village where she was born twenty-seven years ago. As the third daughter of the fourth wife of her influential father – who had been a *Chef de Poste Agricole*[1] – she had many brothers and even more sisters, of whom especially one took care of her from the age of five onwards.[2] Remaining childless within her marriage, this sister took Sophie in order to 'have someone around to help her out with household chores'. Next to her sister's lessons in and around the house, Sophie also had the chance to enjoy formal education. She went to schools in different cities; as the husband of her sister had a mobile job, Sophie was taken along to Bélabo and the capital of Yaoundé where she did well in class. After finishing her primary education, her father, who had the financial means and the ambition to get all his daughters properly instructed, sent Sophie to secondary schools in the cities of Bélabo and Bertoua – an unusual but increasingly popular opportunity for girls at that time. Sophie loved especially her dactylographic courses, where she discovered her 'talent' and came to imagine a future as a typist. But then her father became seriously ill. The money that had enabled Sophie to pursue her education was now invested in his hospital visits and operations. School was over for Sophie.

In this indecisive period, in which future prospects were destroyed and Sophie experienced her daily activities as being 'without any goal or development', she became receptive to the temptations offered by boyfriends. Presented with their gifts and financial rewards, Sophie 'started to like the taste of it'. Not long afterwards, at the age of seventeen, she conceived in one of these relationships:

> He just helped me out, bit by bit, until the moment he would 'have' me. And then, it was over. For me, that pregnancy really came as an accident. I thought, 'If my father will hear that I'm pregnant, what will happen?' And my friends would make fun of me. I was so ashamed. So I told my boyfriend that I would search for people who would give me remedies to abort the pregnancy. He said that if I would do that, I would die. In that way, he cursed me and that made me afraid. I was forced to keep the pregnancy.

Next to feelings of fear and her boyfriend's curse, a lack of financial means and knowledge of abortion methods hampered the actual realization of Sophie's wish for an abortion. When her boyfriend eventually gave her money and told her to go to the hospital to have an abortion, most of these constraints suddenly seemed to disappear. However, her boyfriend's proposal turned out to be a pretext to get her to attend prenatal consultations; considering the advanced gestational stage, the doctor instantly refused an abortion and proposed a medical follow-up of Sophie's pregnancy instead – something her boyfriend had apparently anticipated. This incident made Sophie feel naïve, disappointed, and forced into keeping the unforeseen pregnancy; at the same time, however, it helped to appease the reaction of her parents. Although they did not like the news, what mattered most for them was that Sophie's boyfriend had assumed this (financial) responsibility and care for their daughter's pregnancy. This is not to say that they expected anything *more* from him; instead, they strongly supported Sophie's explicit marriage refusal:

> I did not want to marry him. I wanted to ensure my future first. This boyfriend didn't have a stable job. So I told him that I couldn't marry a man who doesn't do anything. And what is more, he also had a wife and children. I don't like polygamy. My boyfriend insisted that I should marry him, especially when he saw that I gave birth to a daughter. His wife had only given sons to him, so he really wanted me to come and join his family with my baby. But I resisted. Even if there is a child in between us now, that's okay, but that's it.

Especially Sophie's father, who had invested his financial means in his daughter's education, clearly envisioned another future for Sophie than this 'down-and-out' guy ('*va-nu-pieds*') would probably have been able to offer her. He insisted that even if there was a child, Sophie should still be able to go to school or work without being burdened by mothering tasks or by entry into marriage. These ambitions were quickly realized when soon after the birth of her daughter, Sophie was unexpectedly proposed a teaching job as a dactylographer. She went to live with her maternal grandmother in the city, who took care of her baby whenever Sophie went to school to teach. Sophie's motherhood did thus not interfere with her daily activities or projects for the future; to the contrary, it

even played a decisive role in the relationship with the man who would eventually become her husband. Seeing the 'proof' of her fertility, Alain became interested in Sophie. As he really longed for children at that moment – being the only child of his mother, and having no descendants since he had been together with several infertile women – he quickly started preparing the traditional gifts to her family as soon as Sophie carried his pregnancy. However, the then 18 year old Sophie considered herself too young to bear a second child and tried to abort the unexpected pregnancy:

> I didn't know that I would get pregnant that easily again and I wanted to get rid of it. Me again? Bearing a second child? Whereas my friends were still in school…I didn't want that, because I knew that one day I would want to go back to school as well. I talked with Celestine about it and she agreed that I should abort. She said, 'Look at your age. You want to bear your second child already? Don't do it'. So I asked people to help me, but nobody gave me the right remedies. One woman gave me a thing to insert [vaginally] and open the uterus. I tried to find the courage to do this, all alone, in the middle of the night. I did it three times. But fear overwhelmed me and I stopped. I told myself, 'Let it be. If I force, I might even die. In any case, it is also good to have children'. And my husband also told me, 'If you abort, I will charge a complaint against you'. So he begged over and over again. He convinced me, since he wanted to have children. It is always like that with men: in the beginning, he deceives you and promises everything, so that you get nourished with hope. But as soon as he has you, it's over: he doesn't bother about you anymore. He has already finished you.

Alain proposed to flee to his parents in a village in another province. Not only would they be at a safe distance from Sophie's parents – whose reactions to this second pregnancy both partners feared – but they would also be able to find some financial means that would enable Alain to announce the news 'officially' – i.e. with gifts and red wine – to Sophie's parents, to convince them of his serious intentions and appease their reactions to the situation. What is more, Alain had already informed his parents about Sophie's pregnancy and wanted to present her to them as well – something that is rather uncommon in this very early stage of pregnancy. He thus attempted to inhibit Sophie from aborting an already publicly known pregnancy and to quickly satisfy his parents, who were impatiently waiting for their only son to produce offspring. Things were done as proposed; Sophie left her grandmother, daughter, and the job that she felt nevertheless unsatisfied with, since 'I didn't develop myself in this teaching job and knew that this was not something I would like to do all my life'. In this critical period where abortion failed, fear of her parents prevailed, and her daily life activities were not a satisfactory reason to stay, fleeing to apparently approving and well-positioned parents-in-law – Alain's father was a well-known healer in the region – seemed to offer a suitable way out.

And indeed, she was warmly received by her new in-laws, who once again discouraged her from aborting her pregnancy. Her father-in-law made serious efforts to arrange proper gifts and promised to accompany his son to Sophie's family. Reassured by this eagerness of her husband and in-laws to take her as a wife, Sophie was convinced of the privileged position this marriage could grant her; after all, Alain had an official job as a

teacher at a missionary school and could satisfy her needs with his financial capital, while she could satisfy his and his parents' need for children with her childbearing potential. Their promises with regard to a future marriage eventually also changed the reactions of Sophie's parents – initially menacing because of the secret flight of their daughter with an unknown man. The birth of a daughter, the quick transfer of *medokh meyal* (the wine of birth), the resulting 'friendship' between Sophie's father and father-in-law, and Alain's tactic to move Sophie into his house in the city soon afterwards, finally concluded the marriage.

During the beginning phase of this marriage, a prolonged post-partum taboo was respected for the sake of the well-being of the baby (see also Chapter 2). However, soon after weaning her daughter, Sophie wanted to get pregnant again, for 'since I was a married woman now, it was good to bear a lot of children, even a hundred'. She adapted her sexual practices accordingly:

> I myself know that this or that month, whatever happens, I will conceive. And when I say no, I won't because I will avoid it. Or when I say no but the man says he still wants [to have sex], I have an alternative system: I often take *nivaquine* pills. I either swallow them or insert them down there after sexual intercourse. Or I put some salt in water and I insert it. It removes all the dirt that is inside. After five minutes, I go to the toilet and it will evacuate everything. But if I want to get pregnant, I don't do these things. I just calculate my fertile period and then, automatically, it [the pregnancy] enters. I learned all these things at school.

One month after she had weaned her second daughter, Sophie became pregnant again. However, she miscarried after two months. She relates the incident to me as follows:

> My miscarriage was caused by the women's worm[3] that often picks in the lower abdomen. Even if you are pregnant, the pregnancy will leave [when the worm picks you]. It started picking me when I was already pregnant for two months. When I wanted to urinate, I only saw some spots of blood. Although my aunt had given me some barks [of a medicinal tree] to stop the bleeding, it did not help because the worm was alive. I should first kill it. It is the *mectizan* medicines[4] that have treated this for me. I had gone to the hospital to ask if the *mectizan* that we should take would only kill simple worms. They told me that it even kills the women's worm. I decided to try to take this and it killed the worm. The same month I got pregnant again.
>
> My husband was angry when he heard that I miscarried. He thought it was me who had tried to abort this pregnancy. I told him, 'No, of course I know the methods, but I could never do that. It is a worm'. I also told this to his family members who asked me, 'What is the cause?' When I told them I suffered from the women's worm several people there gave me some remedies, but these were not as effective as the *mectizan.* And then they saw it themselves, because I got pregnant immediately after I took the *mectizan*. That's what they wanted. In the end, they didn't consider it too much, since it was a pregnancy of two months that contains only water.

Her next pregnancy, bringing another daughter, was gladly received by Alain and his parents – to the extent that they proposed a formal, municipal marriage to Sophie. With the prospect of a marriage certificate which would allow her to 'profit even more from his wealth', Sophie was happy to conceive again in the hope of quickening this process. It

was during this fifth pregnancy, however, that, as Sophie tells me, 'everything got spoiled' because of the extramarital affair that her husband became engaged in. It drastically changed his attitude towards Sophie and her children; he was absent most of the time and discarded his financial responsibilities. When Sophie found out that her husband was seeing another woman – who was married, had four children, and was said to have borne a son with Alain – she felt shocked and disappointed. Although she accused the woman of falsely claiming that Alain was the father of her son in order to win his attention, Sophie saw that these lies *did* have an effect on her husband. Alain even denied being the father of Sophie's pregnancy, while taking full responsibility for 'that child outside which is not even his'. Seeing no positive prospects whatsoever and thinking of the burden of her three daughters, Sophie tried to abort this fifth pregnancy but failed again:

> After two weeks of pregnancy I told him that I didn't see my period anymore. He told me, 'If it is a pregnancy, I won't be there. Go and search for someone else to take care of you'. Erica, when a man already has another wife outside, he doesn't pay attention anymore to the one inside his house. Really, I don't refuse to give children, but I won't give them in such a situation. So with this anger, I started drinking [a concoction of] leaves. It didn't work. And people around me did not want me to abort. My mother started screaming that it's far too risky. Even Celestine told me to keep the pregnancy now because a child doesn't last [*l'enfant ne dure pas*]. And many other old women encouraged me to give birth, just like all other married women do. Everyone has problems within marriage, but that shouldn't be a reason to abort. They said that things would get better as soon as I would give birth. One aunt even gave me certain leaves and barks. Some of them I had to eat, others I had to bury in the river, or wash my face with. These would lead to a separation between my husband and his girlfriend because it would undo the effect of her charming remedies. I had understood the message of all these women and kept the pregnancy. But I still call it a 'pregnancy of suffering'.

I wondered why Alain's attitude had changed so drastically – considering that he had first proposed a formal marriage to Sophie. Why would he turn his attention away to the extent that he even denied paternity of Sophie's pregnancy? Had he been pushed by others to do so? Had there been problems that Sophie tried to hide from me? Had her previous miscarriage raised suspicions? Was he afraid of the promised formal engagement? Or was it the son of his *copine* that attracted him more than Sophie's daughters? It never became entirely clear to me. Posing the question directly to Sophie only provoked heavy accusations towards her co-wife, who she claimed was using charming powers in order to totally possess Alain – making him a passive follower of her whims, without any clear reason connected to his relationship with Sophie. When I asked her about the role her in-laws had played in this affair – knowing that tensions in marriage often involve the husband's kin as well – she once again turned the attention to the evil-doings of her co-wife: her in-laws strongly disagreed with the situation and reproached their son for having taken a second wife, but the charming power of this woman made their words ineffective. 'They love me a lot and they pity me', Sophie assured me when I

inquired about her relationship with them. Frictions between herself and her in-laws – so common in the stories of other informants – were downplayed; instead, all attention was turned to the tensions with her co-wife.

It was only when Sophie participated in one of my focus group discussions that I gained a more nuanced understanding of the behaviour of her husband and his mother – both of whom remained abstract personalities to me as I had never met them in person. The discussion focused on the topic of jealousy between mother-in-law and daughter-in-law, both competing for the attention of one man. To my surprise, Sophie cried out that she would advise everybody to marry a husband without a mother, because mothers are so greedy and men are obliged to give in to their wishes. She explained how she used to see her mother-in-law only towards the end of the month when her husband received his salary. Later in the discussion she elaborated:

> I have a mother-in-law who likes to eat (*bouffer*) whenever she can. So when she finds that her son has a mistress and that this mistress is willing to give her something, she will constantly go and visit that girl. That is happening now as well. This woman [her co-wife] is in the house. My mother-in-law hoped for this, because she wants her son to bear many children. Now it appears that it doesn't work out. This woman doesn't produce. She gave all her children in a previous relationship. And automatically, she [mother-in-law] returns to me in order to complain about my co-wife. Now she says, 'No, the other one is not good. When I arrive in my son's house, I don't eat and I don't wash myself anymore. But when you were there, I had nothing to complain about.' But she was the one who wanted this woman in the first place! I, in turn, told her that I wouldn't bear any children anymore.

Was Alain's extramarital affair a search for more descendants influenced by the wishes of his mother? Having only one son, she might indeed have wanted to compensate for her lack of children by fully exploiting him: not only did she claim his financial resources, but also the services and childbearing capacities of his mistresses. If his mother's search for descendants could in itself explain Alain's extramarital relationships – a well-known and dreaded influence of mothers-in-law – his unwillingness to recognize Sophie's pregnancy remains surprising. If he – and his parents – were in desperate search for children, he would have been more than willing to embrace the new pregnancy of his wife.

That there was even more to the situation, I discovered after an unexpected incident. One morning, while Sophie and I were waiting for one of the haphazardly passing cars to take us to an indigenous healer, we 'missed' the occasion while we were drinking tea inside her mother's house. Seeing the car pass by at high speed, Sophie started loudly regretting that we were not outside at this moment, since the taxi-driver was actually one of her recent lovers. Surprised, because she had never mentioned her extramarital affairs to me in our conversations, I asked her whether she had many such lovers. Unequivocally she answered, 'Yes of course, since my husband was only floating outside, I decided to search '*ma part*' as well'.

Though the relationship with Alain improved once her fourth daughter appeared to be 'his picture' and paternity could no longer be denied, problems with her new co-

wife increased after the latter moved into the house. Sophie related how the many fights and harassments between her and her co-wife made the situation unbearable for her. Rather than 'suffer inside', she ran away several times, seeking refuge with her older sisters and mother in Asung. From this time onwards, her mother becomes more visible in Sophie's narrative. Having been raised by her sister, Sophie did not seem to have had a particularly intimate bond with her biological mother during childhood. Things had changed, however, when her mother was chased away to her own family after the death of Sophie's father. Due to the disputes over inheritance that ensued between her and the sons of her three co-wives, Sophie's mother had returned to the *quartier* of her Bibakung brothers on the other side of Asung. Here, her relationship with Sophie improved. Both women defended each other's interests now: Sophie, as a 'sister's daughter' (*mo kal*), had the traditional position to demand certain privileges for her mother in her maternal family, while her mother acted as an important marriage broker and safe haven for her daughter. Nevertheless, despite her help, Sophie's mother insisted on Sophie's eventual return to the marriage. She had various reasons for doing so: she was subjected to the demands of her brothers, who could eventually contest the prolonged stay of their *mo kal* in the compound; she herself felt burdened by her regularly returning daughter and grandchildren; and, most of all, she would be more likely to receive some bride-price payments (especially the *monni niaŋa bon* given to the mother and her sisters) if Sophie endured in the marriage. 'Since there were already children, she said it was not good to really leave them behind like that'.

Thus foreseeing an unpreventable return to her husband, Sophie started to secretly take contraceptive injections in order to prevent another pregnancy with him.[5] But she forgot to attend a follow-up consultation for the contraception and became pregnant again. It was within this context of conjugal turmoil that Sophie experienced another miscarriage:

> It started with pain in my back, around the kidneys. It got really warm. The warmth reached my uterus. I went outside, because I thought that I wanted to urinate. When I squatted, a ball of blood fell down. I looked at it and I said: shit. I stayed for at least thirty minutes in the WC because the blood was flowing. Then, I stood up, went to the house, and changed my clothes. In all this, my husband was there. But he neglected, as always. I suffered a lot afterwards and bled a lot as well. I could only lie down. So my husband told me, 'Take this money and go to the hospital for some injections'. But after this, my husband didn't say anything about it anymore. Because when I ask him, 'What could be the cause of all this? I do not even work hard like women in the village, because we are in the city. So what is it?', then he only tells me to go to the hospital. There, they say I suffer from typhoid. But even now that I am under treatment for this typhoid, my belly is very warm inside. Why doesn't it go away if I take the proper medicine? And look, when I am here in the village, far from my husband and that woman, the situation tends to ameliorate. But when I get back in the city, in my house, problems worsen again. I will never enter that house again as long as that woman resides there. I will not bear children anymore. But my husband does not care about my situation. It is this woman who charmed him.

Although this second miscarriage occurred at a similar phase of pregnancy as the first one, Sophie's experiences were clearly dissimilar. Asked to compare the two events, she reflects:

> There is really a difference. The first time, we found out [about the cause], we treated it, and it cured me. I never encountered the problem again. But this time, even until now, I still feel the pain. And it remains very warm inside. I don't know. I went to the hospital and they say it is typhoid. They prescribed five examinations, but I don't have the [financial] means at the moment to undergo all of them. I would like to start with the hospital and finish these examinations. And then, I will go and see ahead. Because she [her co-wife] practices day and night and she succeeds in it. And I only practice during the day.[6] I searched [for indigenous medicaments] here in the village, but that doesn't work well. It tends to help a bit and then it releases again. So what I want is to go to a *marabout*. I will hear everything that she [her co-wife] is doing and I will be treated.

Indeed, visiting an Islamic healer with me on that day in February proved to be a turning point in Sophie's illness episode. As illustrated above, this *marabout* confirmed that her co-wife had charmed her husband and practiced witchcraft to destroy Sophie's health and conjugal future. She promised to help Sophie in three ways: by restoring Sophie's health and childbearing capacity; by undoing the effect of the co-wife's harmful remedies on Sophie and instead letting them work on the co-wife herself; and by making her husband listen to Sophie again and accept all her proposals. Sophie's search for help had become a contest for power: deprived of financial and social security within the conjugal sphere, she felt compelled to make use of the *marabout*'s offer to 'combat the evil with evil' – the only promising horizon that would enable her to regain her powerful position as a first wife within an urban marriage. When I left the village, Sophie was hopeful about the healer's interventions: her physical ailments were disappearing and her husband seemed willing to listen to her wishes again. Soon she would leave Asung's fields behind and return to the city again. Thanks to her mother, who acted as a broker in this affair, Alain had promised to search for a separate apartment, where Sophie could live on her own – married but far away from her co-wife.

One year later, during my last fieldwork period, Sophie is living together with her daughters in a small wooden two room apartment in Bélabo. Still relying on her petty trade and her mother's help, she relates to me that Alain's moves nevertheless seem promising:

> Since he wants another child, he is trying to come back to me for that, because his wife still didn't bear any children for him. She invented some pregnancies, though, but these always turned out to be lies. My husband doesn't believe her anymore, but he knows that when I say I am pregnant, it is true, because I am so fertile. So I told myself that I should maybe try to give in to him now, despite my anger. Look, I am suffering here outside while she is inside. If I conceive, I know that he will ask me to come back to his house and I will regain my place. And she will be behind me. Maybe he will even chase her. So now that he is deceived by the other, it is time for me to try to get pregnant again. And then, when all things will be settled, I hope to take up my dactylography again and find a real job. The thing is: I need a typewriter to get started and where will I find the money if I'm not even close to my husband?[7]

This firm hope for reconciliation and conception is inspired by her family members, who repeatedly remind her of the need to be married and to raise children in the presence of their father; by her friends, who tell her that her fertility may 'go far away' as she has not carried a pregnancy in the last five years; and by another *marabout*, who provides Sophie with powerful medicines for a future legal monogamous marriage and urban prosperity. With reconciliation with her husband becoming desirable again, Sophie has abandoned her previous boyfriends – not only because of the risks of transmissible diseases, but also since a pregnancy from 'a man outside' would definitely foreclose the still precarious prospect of a return to Alain. The certainty with which she relies on her reproductive capacities now strikes me. When I ask her how she looks back at the previous years in which she feared a permanent loss of fertility, she reinterprets the lack of a pregnancy as a likely result of her own separation from her husband, and of God's approval of her constant prayers asking for Him not to send her another pregnancy. With Alain's return and God's understanding that she is now receptive for another child, Sophie considers a reversal of the situation to be easy and highly probable. And *if* it really was her co-wife who had caused her sub-fertility, her evil powers will soon be eliminated by the remedies of the *marabout*, she reasons. New horizons and hopes thus ask for new reproductive '*politiques*', and a rethinking of former ones.

Just before my final departure from the field, I leave Sophie behind in her mother's house, where she has temporarily come to spend the holidays with her children. Being in the same place and carrying the same bags as upon my arrival a few years earlier, we again look at each other with a mixture of happiness and uncertainty – glad that our paths have crossed in the past, but unsure whether they will continue to do so in the future. As if to take part of the uncertainty away, Sophie reassures me that she will cling to her new project:

> I, I am here [*moi, je suis là*]. I decided that I won't go into another marriage. I am here with my family and I wait for him. I exerted my politics by always keeping my children with me. Unless I die, I know he will always come back, because I have his children. Men just want children, and so they become children themselves in a sense: it is easy for a woman to play with a man in that way. I know that I will be fine in the end. I will leave the fields soon and return to my husband in the city.

≈≈

Even if Sophie's final depiction of her complex experiences as just 'play' may seem simplistic and only part of the story, many urban marriages in this area are in a way indeed a 'bet' – with different ambitions and stakes involved.[8] With more horizons and alternative possibilities present in urban areas, marriage and fertility often acquire different and more volatile meanings than in the village setting described in the previous chapter. These altered meanings and ambitions in turn affect men's and women's

management and interpretations of reproductive interruptions. In order to comprehend these dynamics, the following will first explore what it is that attracts Gbigbil women like Sophie to urban areas in the first place. I will then describe and contextualize the marriage and fertility 'bets' in these settings, and outline how pregnancies and their interruptions might confirm or contradict the 'rules of the game'. An overview of the multiple explanations and negotiations around the (lost) foetus will finally enhance our understanding of why Sophie interpreted and managed her pregnancies and their interruptions in the way she did – during her particular pathway towards urban honour and within the particular marital 'bets' that she encountered along the way.

Urban attractions and ambitions: possible pathways

Gbigbil women from Asung are in many ways confronted with town life. Some, like Sophie, move beyond the rural realm from a young age onwards. Parental liaisons or flexible fostering practices make them accustomed to a mobile lifestyle, in which they regularly stay in urban households and encounter educational, biomedical, juridical, and religious institutions in the surrounding neighbourhoods. Others may only decide to 'search their lives' in the city after having spent considerable time in the village. With Bélabo and Bertoua within reachable distance in both directions of the paved road that traverses the village (see Figure 2), and with Gbigbil acquaintances and bigger markets present in those two cities, these women might at a certain point seriously consider following those who have preceded them and 'try their luck' elsewhere. Whether from the beginning or only later in life, many Gbigbil women thus alternate their stay in Asung with periods spent in urban realms.[9] Their specific reasons for doing so are multiple; but underlying these decisions is a certain view of urban life as offering more attractive possibilities and future prospects than those encountered in the village.

As much as village life is pervaded by the ethics of production and reproduction, urban life is considered its antithesis. Rather than to prioritize 'work in the fields and births of many children', life in cities is thought to centre on other activities which offer alternative future scenarios. My informants claim that its driving force is not subsistence but rather the accumulation of money. The pathway to respectability is not the exposure – and thereby, depletion – of physical force (*ngul*) but rather the exposure of financial capital and of social links with those who possess money. According to many Gbigbil women, a shift to this alternative frame of honour would ensure the preservation of force, youth, and beauty, and would also give them more rest, more time, and more options with regard to productive and reproductive activities than could ever be attained in the village (see Chapter 3).[10] Even if aspirations of an easy and honourable life in the city may not correspond to urban realities, such views and expectations *do* underlie women's decisions to leave the village and 'search their lives' elsewhere.[11]

In this search, several pathways are believed to enhance the realization of urban ambitions. The first and most frequently mentioned route into city life is the educational one.[12] Ever since schooling became widely accessible for both boys and girls during the economically flourishing decades of the 1970s and early 1980s (Johnson-Hanks, 2006, 2007), it has broadened the scope of ambitions and possible futures beyond the village level for men and women alike. With scholastic training perceived as a way to attain formal employment and modern honour, many Gbigbil parents, like Sophie's father, have come to consider the education of at least some of their children a worthwhile investment for an uncertain future.[13] Especially those children who show a particular seriousness or aptness during their first years of life are encouraged to develop their inborn talents and characteristics in school, and thus become a 'real person' (*faŋ mod*) through self-realization (see also Chapter 3).[14] This pro-educational stance is widespread in Southern Cameroon and has been described to logically follow from the 'wealth in knowledge' paradigm long existent in the region. Several sources note how individual talents and characteristics were already an important source of power and respect in the acephalous groups that were scattered through the forest in pre-colonial times; on the basis of outstanding personal qualities and inventive activities, men could attract many followers and wives – and thus, gather 'wealth in people' (Guyer, 1996; Johnson-Hanks, 2006, p. 34; Laburthe-Tolra, 1981).[15] Schooling only reinforces this process of becoming a 'real person' in modern times, for men and women alike. It offers new pathways to respectability and inspires aspirations for other forms of wealth and respect than those related to the village ethics of production and reproduction.[16]

Second, it is through the job market that money, and thereby urban respectability, can be accumulated. The employment that is envisaged here is ideally formal and acquired through a certain level of education. A salaried job is, in the current atmosphere of economic decline, an increasingly rare form of capital. Ever since 1994, the year in which the Cameroonian currency devaluated, civil servant salaries have drastically decreased (with cuts of up to 70-80%) and unemployment rates have been on the increase. Those who succeed in being formally employed are therefore likely to be surrounded and respected by the many others who have not; it offers them not only financial, but certainly also symbolic and social capital. But even those who do *not* succeed in getting a formal job – people with a lower educational level, or who are well-educated but hampered by current high unemployment rates – might still be enviable from the villagers' point of view. They can become successful through inventive income generating practices on the Cameroonian informal markets, which are related to state institutions in complex ways (see also Geschiere & Konings, 1993; Goheen, 1993; Guyer, 1996; van Santen, 1993). Gbigbil women who have less experience with schooling than with work in the fields and in the kitchen may aim for exactly such a career; they become involved in small-scale trade, prepare dishes to sell at urban roadsides, or try to compete

with *bayams* from Yaoundé and Ngaoundéré by buying products in surrounding villages and reselling them in town markets.

Third, urban honour can be achieved through prestigious liaisons such as sexual relationships, marital alliances, kinship connections, or clientism with urban elites (see also Abega, 2007, p. 126). For many Gbigbil women, the preferred pathway into an urban lifestyle is based upon relationships with rich men who have already established themselves in the area. Through the money of these men, women may attain the luxurious and respected lifestyles they are aiming for; through the connections these established men open up to them, they may access formal jobs or other opportunities. What has been described for elite women in the West of Cameroon is exactly what is aspired to by my city-oriented informants in the East:

> Elite wives also assume household responsibilities, but contrary to their poorer sisters, they can access resources that allow them to directly contribute with money to the accumulation of the household. Elite men invest voluntarily in the career and enterprise of their wife, paying costs for school or training, or lending them money to help them in their affairs. Wives of elite men often have a salaried employment and, moreover, can invest more in commerce and hire workforce in the household. (…) Elite wives can expand their own networks of accumulation and reciprocity and, with their husband, reproduce a 'modern' lifestyle, often characterized by 'western' or 'modern' commodities such as clothes, television sets and padded furniture (Goheen, 1993, pp. 263-265, my translation).

Goheen argues that with altered material conditions, ideas and ideals of gender and marriage are likely to change as well. Along with different 'relevance rules' (Holtedahl, 1993, p. 275)[17] and 'repertoires of possibilities' (Guyer, 1996)[18] in urban zones, partnership and parenthood are thus presumed to acquire different meanings. The following will explore whether this is the case in the urban surroundings of Asung as well. It will first delve into the dynamics and desires behind the relationships that Gbigbil women engage in during their pathways to urban respectability. Then, women's childbearing intentions within these encounters will be discussed.[19]

Informal insecurities: the 'big fish' bet

As noted before, marital habits have long been in flux in the East Province of Cameroon. Chapter 1 indicated that marriage norms and expectations have probably always diverged from actual conjugal practices in the region (now and in the past), and Chapter 3 exemplified how this discrepancy can work out in the village; the following will explore how marital relationships acquire different meanings again in the face of multiple urban horizons and alternative forms of honour. Where schooling and formal jobs are present and explicitly aimed for, marriage and parenthood cease to be the only means to attain respectability; they seem to become relevant only *later* in life. As several studies have indicated, there has been a visible trend, especially from the mid-1980s onwards, of rising marriage ages for both men and women in urban areas all over Cameroon (Calvès, 1999,

2000; Garenne, 2004; Johnson-Hanks, 2007). This has in turn engendered a proliferation of premarital sexual relationships, which might or might not culminate in what is finally agreed to be a marriage, in these zones.[20] Such relationships often attain different intensities, serve different interests, and acquire different meanings for Gbigbil women and men who face multiple horizons and aim to pursue particular urban projects.

The most common and volatile form of sexual relationship is called a 'simple friendship' (*amitié simple*).[21] Such a 'friendship' is constituted by a gendered exchange of food, sex, and money: men give money for food and other gifts, women cook for and sleep with men. Yet, the two 'friends' do not live together. The relationship persists as long as some kind of reciprocity is maintained between the partners; clear future visions or further commitments are mostly absent. Most women stress the attention, gifts, and support these friendships might offer them. As Sophie indicated for the father of her first child, 'He just helped me out, bit by bit' – but a marriage with him was out of the question. 'We just want wealth', my informant Diana once told her husband Baudouin when he complained to me that many women these days maintain multiple *amitiés* simultaneously. Indeed, if financial support is what is aimed for, the best strategy for women is to engage in 'simple friendships' with more than one man – since all 'friends' will face economic shortages now and then, or at least claim to do so. These men might have several other girlfriends, who all 'demand their parts', or even be married with children. Likewise, not only 'free' girls (*ngon sí*) but also married women who feel (financially) unsatisfied with their husbands might engage in extramarital 'friendships' with other men – provided that these are veiled in secrecy. Thus, both men and women have multiple *amitiés* and are free to bring these to an end if they lose interest for some reason or another.

While such pre- or extramarital 'friendships' are common in both rural and urban areas, they acquire particular meanings for unmarried women who aim for a future in the city. These women often explicitly attempt to be involved with the most respected and well-to-do men in urban environments – preferably older men with formal employment. Such partners are called *gros poissons* ('big fish') by my informants; 'a good catch which might be able to fill your stomach'.[22] Laura explains:

> A big fish is somebody who has financial means. People like the prefect, the mayor, a commandant, or chauffeurs are all big fish. We engage with them for the honour to live with somebody who earns money. It is not necessarily a marriage with them that we want.

Through the material and symbolic advantages accruing from reciprocal 'friendships' with these rich men, women aim to attain their aspired goals of urban luxury and dignity as outlined above. In this, they are often encouraged by their relatives. With the eventual transfer of a bride-price far from secured in the current era of economic and conjugal instability, family members at least try to profit from – if not some parts of the bride-price

– the gifts and connections these rich men may offer their daughter and themselves (see also Abega, 2007, p. 86)

But even if they are aspired to by women and their families, relationships with 'big fish' are often surrounded by ambivalence as well. Due to their wealth and status, these men are solicited by many women (and their families) alike and have to distribute their attention and money over multiple partners. Long-term relationships with 'big fish' are therefore considered unfeasible; most lovers rather seek for instantaneous advantages. As Laura noted above, intense engagements are also not necessarily what women *aim for*; a hypothetical entrance into marriage is by many of them conceived as a possible obstruction to other non-marital ambitions (verbalized by the phrase '*c'est fini pour toi*', meaning 'it is finished for you'; see also Goheen, 1993, p. 267).

Consequently, as much as they are a source of temporary pride and respect amongst women who wish to embed themselves in urban circles, these relationships are often considered appalling examples of women 'selling their bodies' by others – especially elders in the village. Even relationships with '*va-nu-pieds*' ('down-and-out' guys), as Sophie called the father of her first child, which are all too clearly based on material interests – or in other ways violate the reciprocal 'rules of the game' – might be labelled as despicable instances of *escroquerie* (exploitation) or *bordellerie* (prostitution).[23] The first epigraph to this chapter shows part of this story. It is the beginning of a song by the blind Cameroonian artist *Prince Aimé* ('Beloved Prince'), who describes how he spent all his money on gifts for his demanding girlfriend Viviane. However, when he fell short of money, she suddenly disappeared. Recognizing her passing by on the street in the company of another man, *Prince Aimé* was ignored, insulted, and pushed away by Viviane. The deception described in the end of the song underlines the materiality, volatility, and distrust that pervade many current *amitiés*. Online reactions to the clip on *YouTube* show a general acknowledgment by Cameroonian men and women alike of the depicted situation, and reveal some moral ambiguities that surround the image of women's use of strategic sex: [24]

> We women, we are very strong! We pretend to love whereas to the contrary, it is only the money that we love. Let's change our behaviour.
>
> What you are saying is very true!!!!!!!!!! People please beware of all the Vivianes.
>
> Today everybody is Viviane in a way, even men. Let's pray every day that this spirit of *escroquerie* disappears, because it's better to take the money of a man that you love.
>
> Cameroonian girls are CameRUINean, so what? Is it only us? Let us be!
>
> Everywhere on the world women are the same. In fact, it is the nature of a human being. Too bad for the unlucky ones. Just use your brains and not your emotions.

While the first two reactions acknowledge but implicitly condemn Viviane's attitude, the latter two naturalize and celebrate it. As seen above, both extremes were uttered by my

Gbibgil informants as well. The middle comment is more nuanced; it indicates that this behaviour applies to both men and women, and to both relationships based on *escroquerie* and those characterized by love. It is exactly this nuanced remark that sheds light on the ambiguities of relations with 'big fish'; for, as much as the unconditional exchanges may constitute a factor of instability, they could serve as a basis for a 'deep friendship' (*amitié profonde*) or 'serious engagement' (*fiançailles*). The exchange of sex, food, and money is part of *every* intimate relationship in Eastern Cameroon – whatever its duration and outcome. It is thus a cornerstone of relationships that *are* intended to be serious and long lasting as well. Male attention in the form of money and gifts serves, as it has long done, as an indicator of his potential as a future spouse; it is considered a proof of his love, responsibility, and serious intentions. Women's sexual relationships with 'big fish' are thus ambiguous: while they can be instrumental for the achievement of other urban goals like schooling, employment, or pecuniary honour, their stabilization can at the same time become a goal for those women who aspire to an urban marriage with a promising husband.

The sexual behaviour of Cameroonian men shows similar ambiguities. Like their female counterparts, urban men have several reasons to postpone and keep informal their marital engagements. Multiple, volatile sexual encounters offer them the possibility to 'search a life' before getting married and having children; they may lead to financial benefits (especially from older, well-to-do women); they provide status among peers and family members, who generally value the display of masculinity and potency;[25] or they exist simply because men have limited capabilities to fulfil formal marriage obligations. This is not to say that marriage in itself is not valued by these men. For, in the midst of their '*multipartenariat*', they are prone to search for the 'best girlfriend' (*meilleure copine*), who might sooner or later become a spouse.[26] Apart from behavioural characteristics, women's educational level is hereby often explicitly taken into account (Goheen, 1993, pp. 263-265; Holtedahl, 1993, p. 287; Meekers & Calvès, 1997). A Gbigbil student in Yaoundé explained his deliberations after he had interrupted our conversation when a young girl walked by. With a low voice, he had asked her whether she could tell her older sister that he wanted to meet her that night. When I inquired whether that sister could be considered his girlfriend, he said:

> You know? Many girls here are *zam zam*: they go from one guy to the other and are not really serious. I don't like that. I want a serious girl and an educated one, like this one. I hope she will become my best girlfriend. But for the moment, I have several girlfriends. Oh, as a man you cannot stick to one girlfriend only. Maybe you would say that she's your everything and that you only go for her. Well, and after some time, you'll find out that she is not the way you initially hoped she would be. She can display certain characteristics that you hadn't expected or she seems not well educated. Briefly, you can't imagine a marriage with her. And then you have no alternatives. So it is better to have different girlfriends at the same time. And women do the same, you know. They have several boyfriends and choose the most serious one amongst them.

What becomes clear is that sexual relationships are fraught with mutual mistrust. While this might be true everywhere in Cameroon, it becomes exacerbated in urban settings where alternative horizons create more independence between partners. The presence of alternative projects, the high level of competition and competence on a flexible marriage market where men and women aim for the most profitable partners, as well as a general lack of bride-price payments once engagements become more serious, all imbue urban 'partner plays' with ambiguity. This does not, however, do away with the *ultimate* goal of marriage in life, as other studies have also noted (Calvès, 1999; Goheen, 1993; Johnson-Hanks, 2006, 2007; Yana, 1998). Nor does it alter long-standing expectations of gendered reciprocity between possible marriage partners (and their families). To the contrary, the 'commoditization of sex' before marriage and the value women attach to men's financial generosity should not only be placed in the current conjuncture of economic crisis – as transactionalist interpretations tend to do (Dunkle et al., 2007; Hunter, 2002; Leclerc-Madlala, 2003; Nyamnjoh, 2005; and criticized by Poulin, 2007; Tawfik & Watkins, 2007) – but also in a historical context where 'the social structure of marriage exchanges centred on bridewealth, in which a man's commitment to a relationship is measured in the frequency and extravagance of his gifts' (Johnson-Hanks, 2007, p. 651). Even if long-standing gendered reciprocities may have become reconfigured into new *forms* of partnerships in urban zones, marriage as an ultimate *framework* for respectability remains intact. It is just no longer necessarily the *only* aspiration, and therefore might be put within a larger frame of projects.

The next section explores the place of pregnancies in this 'larger frame of projects'. It describes the consequences of conception for the direction taken both within women's particular partner plays and on their broader pathways to urban respectability. Insight into the stakes and projects around these pregnancies allows for an understanding of the meanings and management of fertility interruptions. This, in turn, will help us make sense of Sophie's reproductive decision-making, as recounted in the beginning of this chapter.

'The vagina doesn't talk': flexible motherhood and false fatherhood

Charlotte: It is very simple to mislead men.
Dorine: Especially women can easily mislead men, since women are wiser than men.
Charlotte: A man only knows that he has a wife. But he doesn't know how his wife often conceives a pregnancy.
Nadine: You only tell him you are already pregnant.
Charlotte: He will ask you when it has entered. It is up to you to tell him the day and the date that you did something together. And he will have to believe it.
Dorine: Haha, a woman? A woman is very strong!
Nadine: Criminal!
Angélique: First devil!
Dorine: Because there are things that a woman does and a man can never know. You pretend that you walk together, but…

> *Charlotte*: If God will succeed to put me in a marriage, I will be with my husband. But when another man flirts with me and my heart also wants to go there, I will run very fast as soon as my husband is at a minor distance. And nobody will know what I have done.
> *Nadine*: The vagina doesn't talk. And yet, it has already worked!

Although the above excerpt forms part of a focus group discussion on women's general forces and tactics, it is not surprising that the particular youngsters speaking here had all been in relationships with 'big fish'. It is especially in informal sexual liaisons with urban men that women's manipulation in affairs of love, sex, and reproduction is warranted. With these ambiguous relationships being as easily dissolvable as possibly leading to more formal engagements, pregnancies often have a major impact on the direction and steps taken in the partner play. Depending on the circumstances and the aspirations at hand, they can do both – i.e. either immediately disrupt a relationship, or stabilize it into a 'deeper friendship' or even marriage. As fertility is not always explicitly aimed for, nor necessarily leading to subsequent engagement, pregnancies, even more than these sexual relationships themselves, constitute a 'bet'. The meanings and implications of conception for such relationships are subject to constant negotiation between the two partners and their families; once a pregnancy 'enters', previous pathways may be rethought, new projects considered, and shifting situations manipulated.

For many women with urban aspirations, conception is perceived to stand in the way of the realization of their ambitions. The often related expression '*c'est fini pour toi*' (see also Goheen, 1993, p. 267) verbalizes the idea that a pregnancy, just like a marriage, might prevent the fulfilment of one's projects and foreclose the horizons that had appeared on the pathway towards city life. Although pregnant youngsters in Cameroon are legally allowed to continue schooling after a maternity leave[27], in practice many school-going women fear losing their educational opportunities – or subsequent employment chances, for that matter – once they are confronted with a pregnancy. Their fear seems justified by the reportedly high pregnancy-related dropout rates in secondary schools in Cameroon (Eloundou-Enyegue, 2004; Eloundou-Enyegue et al., 2004; Lloyd & Mensch, 2008). It is further reinforced by public advertisements against 'untimely pregnancies' (*grossesses précoces*) that the Cameroonian media disseminate. The poster below shows how, of two school girls called Clarisse and Angeline, the former ends up poorly after she conceives with a temporary lover, whereas the latter, who finishes school while abstaining from sex, faces a bright future as a good looking, motor-riding (and thus probably employed) woman.

Figure 8 Poster disseminated by the NGO ASAD (located in Bertoua)

The headlines on the poster state the following: 'Which future for us young girls?', 'Bad company reserves us unpleasant surprises. Let's avoid them!', 'Untimely pregnancy, cause of school abandonment', 'Risky sexual behaviour = broken future', 'A good education is guarantee of success and prosperity', 'Premature maternities weaken our body and expose us to STD/HIV/AIDS', 'An educated and healthy girl has more chance to have a good job and an elevated salary'.

It is the fear of ending up like Clarisse and missing the chances of Angeline that underlies the stories of my school-going informants relating (failed or successful) abortion attempts – stories which feed into research findings showing relatively high abortion rates among school-going women in southern Cameroon (Calvès, 2002; Johnson-Hanks, 2002a). This is not to say, however, that the link between school enrolment and fertility desires and outcomes is straightforward or unambiguous, as others have also acknowledged (Basu, 2002; C. Bledsoe et al., 1999; Jejeebhoy, 1995; Johnson-Hanks, 2006; Lloyd & Mensch, 2008).[28] The entrance of a pregnancy does not automatically imply an entrance into motherhood or wifehood for Gbigbil women. Stories of informants like Sophie, as well as other studies in the region, show the possibility for young women to send their children to their father's household or to relinquish parental rights to other relatives in order to circumvent motherhood or wifehood and continue education after birth (Johnson-Hanks, 2002b, 2006). With sufficient social capital and support – either from their partner or family, or both – a pregnancy does not necessarily interfere with urban projects, even if it might initially be perceived as such.

For others, a pregnancy – just like a sexual relationship – forms exactly a *means* to realize urban ambitions since it may ensure financial support from and a symbolic link to a respected man in the city. Especially when a relationship with a certain man seems profitable to a woman, a pregnancy might be a worthy try to 'stick' this partner to her – at least temporarily. In this sense, the best strategy is to conceive with a 'big fish' – or, otherwise, tactically allot a pregnancy to 'the best positioned' lover who is *not* the biological father of the child. Even if a marriage is not directly what is envisaged, a woman who succeeds in convincing her partner of his fatherhood – and gets him to openly acknowledge it – expects herself more or less reassured of care, financial support, and increased contact during pregnancy and the first years of her child's life. In the current absence of bride-price payments (which used to establish a husband's paternal rights over all the children his wife would bear), some unwritten rules have developed which ensure a man's *de facto* right over his descendants as long as he acknowledges his paternity and provides financially for mother and child (see also Chapter 1). Mere impregnation is not sufficient; fatherhood should be socially achieved. Women 'play' with their partners – especially those expressing a wish for children – accordingly. The experience of Charlotte, a pretty woman who worked in a city bar and was tellingly nicknamed 'the hot one', resonates with the stories of many others:

> When it was still a pregnancy of one or two months, I told my sisters, 'Don't tell anybody. I myself will know to whom I will give my child. Then, I know that I won't suffer anymore like I suffer now. If the guy to whom I will give my pregnancy really wants a child, he will look after me and the child'. Because there were two of them in Bertoua. One was married and the other was not. So I asked both of them for the layette – both the father of my child and the other whom I had also told that he had impregnated me. Both of them have come, hey! We first saw a car arrive with soap, fish, and meat. And then the second father of my child came with a car full of food as well. Sacks of rice, boxes of soap, food, fish, meat, everything! Just to come and see the child. He thought it was his child. And we didn't want to deny it. So we said, 'Well, here is your child. Do you see how the child resembles you?' He looked at the child and said, 'This is my blood'. Haha, I thought, 'Ah, if only you knew'. Oh, I have played with men! But my people have drunk, my people have eaten.

Charlotte did not envisage marriage *per se*; she contented herself (and her family) with the material benefits as well as the symbolic liaisons that this deliberate allotment of her pregnancy could offer her. She capitalized on the strong wish for offspring that several lovers had apparently expressed – without necessarily expecting further formal engagements.

Other women *do* try to enforce marriage once they recognize a certain willingness in a man to engage – even if he is not the biological father of the child she is carrying. In these cases, what is aspired to is the honour of being married in general (for, as stated, marriage remains an *ultimate* framework of respectability, also in cities) or of living with an urban 'big fish' in particular.[29] This last motivation was suspected by Sophie to underlie the sudden entrance in the house of her co-wife, with a child claimed to be Alain's. Indeed, in order to attain their marital goals, women often tactically deploy an age-old

norm that links childbearing to a marital framework; they posit marriage as an unpreventable outcome of a pregnancy conceived in an urban affair. Although this norm is mostly not adhered to in practice, it *is* resorted to in women's attempts to alleviate the uncertainty of, and give direction to, indeterminate relationships. A case in point is the story of Joséphine, who conceived with a well-to-do lover while she was following education in Bertoua. Her initial reaction to her pregnancy was one of disappointment: it would 'spoil her future'. But once this lover had openly declared that he 'did not want to flee the pregnancy' and assured his accountability in front of her family members, Joséphine reflected about the option of a future marriage with him:

> I'm not sure whether he will marry me. He has his wife. But they have only two children. I carry his third child. So I pray to God that I will profit from the child that links us already. Because I don't see how my parents here will be able to send me to school again. So if I could only profit in that respect… My education should not fall in the water. I didn't study for nothing. I hope, I impose, I insist. If he could at least help me find a job, I will search my life. And he will search his part of life as well. That's fine. But if he tells me now that I should even marry him, I will do so. What can I do? We already have a child.

Joséphine's last two sentences present marriage as the unpreventable outcome of an unanticipated reproductive conjuncture, while in fact it might be the most promising 'horizon' at hand. Indeed, the prospect of realizing her educational ambitions by going into marriage with a well-to-do man may have contributed to Joséphine's seemingly passive acceptance of this option. A marriage is now a desirable new project because it might safeguard her urban aspirations; her pregnancy is used as a first step in the right direction.

Some others go even one step further: they take their ambition of an honourable urban marriage as the *starting point* and strategically disclose their pregnancies accordingly – in the hope that at least somebody in the city would take fatherhood as an incentive for more formal marriage arrangements. Nadine's story shows how her pregnancy was turned into a possible pathway to an urban future even before concrete horizons in that direction had opened up:

> Nadine has borne six children with four men, and lost one girl and all of her three boys. Her two remaining daughters live with her ex-husband. The death of her last son has triggered a situation in which she is left with no children to care for, no stable relationship with the boy's father Didier (considered as her informal 'husband'), and no clear future perspectives. When she is offered a job as a servant in Douala, Cameroon's economic capital, Nadine gladly accepts and leaves the village behind to 'search her life' in the big city. Finding only hard working conditions and many poor lovers unwilling to assume a responsible relationship, however, she decides to return to her natal village nine months later. Here she detects that Didier has had relationships with two other women, but also that she has missed her period. She concludes that she must have conceived with a married man she used to go out with in Douala.
>
> After an initial wish for an abortion of what would become a 'bastard child', Nadine decides to keep the pregnancy; this pregnant state might enable her to undergo treatment for the affliction (*iwō*) that she suspects caused her previous children's deaths.[30] At the same

time, this pregnancy might help her find a marriage somewhere in a city; now that gossip about her marital instability abounds in the village, Nadine would like to restore her honour through marrying a respected man elsewhere. This might at the same time prevent her child from being the 'bastard child' she initially feared it would become. The question is thus to whom to 'give' her pregnancy. Three men enter the stage: next to the biological father from Douala and her socially recognized husband in the village, she thinks of another promising candidate: the driver of the car she travelled with on her way back from Douala. As a man without a wife and with a formal job in the provincial capital, this driver quickly turned into one of Nadine's lovers worthy of imagining a shared future with – more than the two other men at this moment. For, Nadine contemplates, the man in Douala would never believe in her being pregnant; instead, 'he will only think that I want to eat [*bouffer*] his money'. A formal engagement with this married man is thus highly unlikely. Didier, on the other hand, has proven to be promiscuous and is moreover based in the village – a place that she seriously considers leaving now that it is associated with deception, child death, hard work, and gossip. She therefore concludes that, 'If the chauffeur wants to continue, I will tell him he should take me, including my pregnancy. But not now, because we just started and he will not believe this pregnancy is his. I have to wait a bit first, then reveal my pregnancy, and see what he decides'.

Starting her treatment itinerary while still contemplating about a possible father, Nadine is then told by an indigenous healer in the village that, to heal her affliction effectively, she needs the cooperation of the father of the pregnancy – which is assumed to be Didier. Due to his physical proximity and her desire to be treated, Nadine switches focus and tells Didier that the pregnancy she carries is his. Didier agrees to cooperate in the treatment. But when he later finds out that she conceived the pregnancy in Douala, he breaks all contact. With no other men in the direct neighbourhood to run to, and with the burden of shame and family curses caused by her capricious marital behaviour, Nadine decides for an abortion. Yet, after some failed abortion attempts, Didier begs her to keep the pregnancy, despite his ambivalence regarding his paternity. A future marriage with him is again envisaged and negotiated: Didier proposes to fully engage once a blood test on the newborn baby confirms his paternity; Nadine demands his future faithfulness and their relocation to the city.

However, when Didier traces several of Nadine's lovers on her mobile phone, his uncertainty about his paternity is exacerbated and he breaks all contact again. This, together with the subsequent curses Nadine receives from several family members, strengthens Nadine's wish to leave the village forever. When she coincidentally receives a phone call from the taxi driver, she immediately tells him she carries his pregnancy. The man is overwhelmed and asks her for time to reflect. In this undecided period I ask Nadine about her hopes for the future, whereupon she answers: 'The ball is still turning. My chance will fall wherever it falls. If it is with Didier, I will return there. But he knows my conditions; I decided not to work in the fields anymore and to go to the city instead. Even if he doesn't agree, I will leave. And if I succeed at the other side [i.e. with the driver], I will block him [i.e. Didier] for sure. It's very simple: if a man gives you a pregnancy, and you see that he's not well situated, but you see that another one is better off, you can balance them. So I balance the two and will see where it will end'.

Within a time-frame of only a few weeks, several opportunities and obstructions presented themselves to Nadine. She constantly adapted her ambitions with regard to fertility and marriage accordingly – without, however, losing sight of the bigger urban aspirations that she aimed to realize through this pregnancy.

While it has become clear that pregnancies might impede or enhance urban aspirations and be managed accordingly, this is not to say that women's reproductive decision-making is *a priori* calculated. Though some pregnancies may seem to be

strategically anticipated, many women do *not* make rational decisions or calculations about marriage and childbearing – at least not *before* becoming pregnant. Most of the stories of my informants show how things just happen without anticipation, how their own wishes or future visions are often unclear and inconsistent, or how their pregnancy-related projects are shaped only *after* conception by the decisions of their family members and partners.

Relatives influence the negotiations around sexuality and reproduction considerably. Even if they are located some distance away in the village, they often actively interfere in the reproductive affairs of their promising daughters, for whom certain future pathways had been anticipated. In line with their own needs and aspirations, they sometimes reject premarital pregnancies, while at other times they encourage them; they sometimes focus on the financial and marital duties of the father, while at other times they strategically align a child to their own family. Sophie's story shows that the same holds for parents-in-law, who may influence the marital choices and fertility wishes of their sons who have become 'big fish' – and thereby also those of their girlfriends and (potential) wives. Women's ambitions, negotiations, and decisions should therefore always be considered in the light of the social bodies and social capital established *before* and *during* the reproductive conjunctures at hand (see also Van der Sijpt, 2010b; Van der Sijpt, forthcoming-b).

This navigation is also influenced by the behaviour and intentions of male partners. Like their female counterparts, Gbigbil men might have multiple aspirations at the same time – contrary to the Gbigbil song in the epigraph which presents all men as only calculating for, and desirable to profit from, women's fertility, and contrary to patrilineal ideals which proclaim a persistent male desire for offspring. A pregnancy may be considered a burden by those who still want to 'search their lives', who lack financial means to raise the future child properly (since 'everything needs to be paid for in the city'), who have money but prefer to spend it on other things, or who do not feel like engaging with the woman who claims to be pregnant. Reluctance to acknowledge paternity may also derive from their recognition of women's manoeuvres with regard to motherhood and wifehood; after all, it is only the woman who knows for sure whose pregnancy she carries – and to whom she wants to 'give' it (see also Cornwall, 2007b, pp. 245-246). It is this worry that bothers all three appointed fathers in Nadine's story.

Confronted with a pregnancy of which they are not certain to *be* the father, or to *want* to be the father, men have several options: abandoning the pregnant woman, acknowledging the relationship, acknowledging the pregnancy, or acknowledging both. With no formalities established, no financial obligations yet fulfilled, and often even no internal stability of the relationship with their pregnant girlfriends, men are relatively free to decide what to do when they are appointed as future fathers. While this is the case for men with rural and urban aspirations alike, a study by Calvès (2000, p. 452) shows that this decision seems most related to both the desirability of conception and the

characteristics of the union – that is, men's aspiration to have a child or not at a particular moment and the (in)formality of the relationship in which the pregnancy appears.[31] Paternity is more likely to become contested by men with urban aspirations or in informal urban relationships – even if contestation also occurs in the village or, as Alain's sudden misrecognition of Sophie's pregnancy illustrates, after a considerable amount of time has been spent together and childbearing had become a common project.

Men who *do* explicitly aim to find (or keep) a suitable marriage partner and/or her children acknowledge that there is actually little that they can do to prevent 'false fatherhood'. Some try to calculate the menstrual cycle of their wives or girlfriends as accurately as possible or use condoms in risky periods or relationships; in this light, it may not be surprising that urban Cameroonian men report a higher willingness to use a condom in their sexual relationships than do their female counterparts (Meekers & Klein, 2002a, 2002b).[32] Others, like Nadine's 'husband' Didier, threaten to conduct a blood test on the newborn baby – which they almost never do in practice. Still others, such as Sophie's husband who rejoiced in the fact that his last daughter turned out to be 'his picture', rely on the 'force of blood' which will either show common physical traits between father and child (see also Chapter 2) or direct the latter to its biological genitor even years after birth. Finally, those who are desperate for children resign themselves to the fact that women have a final say in these affairs; since 'the vagina doesn't talk', it is only the talk of the woman that counts. Baudouin, who returned to the village after several relationships with urban women who appeared to be infertile, explains:

> The majority [of men] is very often just happy to follow the words of the woman: 'He is the one who gave me this pregnancy'. And directly, you are proud to hear that this child belongs to you. Even if there are ten men… girls of these days 'balance' men. The one has a bit more means, the other is too poor. Even if it is the poor one who made her pregnant, she will say that it's the other. And since we [men] are lonely, we are thirsty for children. Even if we have ten [children], we always want even one more. So when they come to tell you that 'You have made me pregnant', it always brings joy. You know that you have another child. Even if, in reality, it is not yours.

According to my informants, this pattern of 'selective recognition and support' (Calvès, 2000, p. 446), in which various options and degrees of paternal acknowledgment are possible, differs substantively from former times in which bride-price payments automatically ensured paternal rights over the children born in a union – even those conceived with another man outside of marriage. Once men had initiated their bride-price exchanges, all the children their wives would bear would by default belong to their lineage. 'Bastard' children, even if ranking lower socially, would still have a place of belonging in society (Calvès, 2000, p. 444). As one older male informant told me:

> If your wife would suddenly be pregnant, you could never know whether it was your child. But that didn't matter. Especially if there was a bride-price, every child that would be born would be your child. You would take it. We men didn't have any problems with that. It is our child.

Nowadays, with the decrease of bride-price payments, and with several law reforms that disconnect legal partnership and paternity from monetary matrimonial exchanges[33], fatherhood needs to be explicitly acknowledged in marital unions which are not legally established – i.e. the majority of current Cameroonian conjugal relationships.[34] It has thus become more precarious and, as outlined above, contested – especially in urban affairs where men may have other projects than parenthood in mind. The conclusion for the *children* born in such unions is that 'whether the parents have actually concluded a marriage is considerably less important than whether a man is willing to acknowledge fatherhood and to claim the social and economic responsibilities of that role', as Bledsoe and Cohen (1993, p. 80) have observed. Indeed, according to Calvès (2000), paternal recognition is crucial in establishing the economic status, social identity, and access to wealth and inheritance of children born in unstable unions in Cameroon. Without any recognition, these children are more likely to be raised by their maternal grandparents or by their mothers, who, despite their urban ambitions, often lack formal employment or other sources of regular income. While the dependence of these children on their maternal family members is in some cases wished for, in many other cases it is not. Nadine's insistence on finding a possible father out of fear of bearing another 'bastard child' proves that, even if *bâtards* are commonplace these days, the fate of these children are often as unsure and ambiguous as the (urban) relationships in which they were conceived.

It is within these ambiguities around partners, parents, and possible children that the meanings and management of pregnancy interruptions should be situated. The next section aims to do so; it explores how cases of interruption relate to the above described negotiations around the unborn foetus.

Foetal fights: neg(oti)ations around interruptions

The multiple stakes and ambitions that guide women's reproductive navigation after conception are even more at play – and possibly altered again – when these pregnancies are interrupted. The following will demonstrate how such fertility interruptions exacerbate the suspicions that usually surround pregnancies within precarious urban relationships. At the same time, it will become clear how this heightened ambiguity may enable women to state their stakes and assure their aspirations in a more explicit way.

In post-conceptional periods in which reproductive decisions are rarely straightforward, interruptions might first of all appear as imagined *possibilities.* Apart from those instances in which abortion decisions are effectively made (discussed in the next chapter), women may *threaten* to interrupt their pregnancies for multiple reasons. First, it can be a way of putting more pressure on a man to engage; if he is not yet convinced to accept paternity, the prospect of the removal of the unborn foetus may persuade him to do so – either for the sake of the offspring or for the sake of the

relationship with the woman. In this sense, invocations of a possible abortion become a means to 'test' a partner's intentions. Yves, a male informant who was in the process of becoming a 'big fish' for many women, encountered such a situation. During one of our conversations, he received a phone call from a girlfriend, who told him that she had aborted the pregnancy she claimed to be his. After a long story about how the two of them had maintained an informal sexual relationship in urban hotels, he related:

> At a certain point she called me to say that she was pregnant. From me. And if I wouldn't take her in the house, she would abort it. I told her, 'Do not abort, because that is risky and you could die'. But I told her as well that she couldn't come and live with me. I have a wife and four children and that's enough for me. I told her so. Because maybe it was just her way of binding me to her. Maybe she had become pregnant from another man and told me that it was me, because she wanted to marry me. Well, and now she just called to say that she has evacuated the pregnancy. She asked me [rhetorically] whether she could have really kept it, in this situation. Well, that's fine with me. Thank God that she succeeded without any problems.

Second, a woman's invocation of abortion may also be a tactic to receive money from a rich partner who seems from the outset *unwilling* to engage, or with whom she herself is reluctant to intensify the relationship. Whether or not this money is indeed used for an abortion is contingent on subsequent situations or reflections. The next chapter will show how my informant Laura, for instance, rather started prenatal consultations with the money she received. Men, in turn, also find ways to tactically negotiate the demands for abortion money by their pregnant partners. We have seen how Sophie's first boyfriend only gave this money in such an advanced stage of the pregnancy that doctors would surely refuse the abortion and start prenatal consultations instead. Both men and women can thus use the hypothetical option of pregnancy interruption to strengthen their stakes and pursue their projects within (and beyond) the ambiguous partner play. In this, they flexibly deploy existing embryological notions, which on the one hand consider a beginning pregnancy to contain only 'water water', but on the other hand acknowledge the gradual development of a human being (see Chapter 2). Shifting interpretations of what a pregnancy actually *is* inform negotiations of why it should be kept or 'evacuated', and of the implications for previous pathways, present partner plays, and future projects.

When such interruptions become an *actuality*, then, these questions become even more relevant since they determine the degree of *eventfulness* of the reproductive happening. In line with their particular projects, women and their surroundings can either downplay the interruption as a non-eventful 'late' or 'disturbed' period, or make it into an event in which causes and consequences become negotiated, and previous pathways reconsidered. The first option is often deployed when women fear that public knowledge of their pregnancy interruption would interrupt their wider urban ambitions – e.g., schooling that is financially supported by one's parents, or a relationship with a 'big fish' who seems longing for offspring. Especially if they have a mobile lifestyle and maintain volatile relationships that do not imply a constant co-presence of partner, co-wives, in-

laws, or relatives, these women, more than if they had (continuously) lived in the village, have more *possibilities* to hide and dismiss their blood loss – at least in the early stages of a pregnancy.

Sometimes fertility interruptions *cannot* or *should not* pass unnoticed. Once a pregnancy interruption is conceptualized as such, it becomes enmeshed in negotiations and explorations of possible causes. The aetiological repertoire is vast; people might invariably invoke the will of God, heavy work, abrupt body movements, numerous diseases (both 'indigenous' and 'biomedical'), malediction, the administration of indigenous remedies (by themselves or by malevolent others such as jealous co-wives or female competitors), or the manifestation of (their own or others') witchcraft powers (see further Van der Sijpt, 2007; Van der Sijpt & Notermans, 2010).[35] These different naturalistic and personalistic aetiological categories imply various degrees of culpability and possibilities of accusation; they therefore allow for a flexible idiom that can be differently employed at different moments. Depending on the social situations and personal aspirations, women whose pregnancy has been interrupted can turn the attention either to something negligible ('work' or 'the women's worm'), to an abstract agent ('God' or 'the witches'), or to specific people with whom social relations have been distorted ('my jealous co-wife' or 'my mother who cursed me').

Such tactical and situational aetiological allotments are even more warranted since pregnancy interruptions raise implicit questions of one's *own* intentionality. Many informants, when asked what could possibly interrupt a pregnancy, immediately stressed the point made by Solange:

> Most of the miscarriages are in fact provoked by the woman herself. She thinks, 'I will take remedies which will provoke the child to leave'. And it will leave indeed. Instead of saying that it was her who has provoked, she is afraid and will say, 'I had a miscarriage'. Whereas it was provoked by herself. That is really an aspect that you have to take into account when people say that it happened accidentally.

What becomes clear is that the dichotomy of spontaneous and induced pregnancy interruptions that dominates the existing literature on reproductive loss is in practice rather blurred. Spontaneous interruptions are often suspected to be provoked; induced abortions are often presented as spontaneous; direct attempts to terminate a pregnancy might fail but bring about interruptions later in pregnancy or in a woman's reproductive career; or, conversely, well-intended practices during pregnancy might unexpectedly lead to its interruption. The question of intentionality, though considered extremely relevant in cases of pregnancy interruption, is often complex and indeterminate for outsiders and even for the aborting women themselves. To portray oneself as a passive sufferer of external causes of loss may thus be a woman's tactic to alleviate this ambiguity and to divert attention from this possible intentional side of pregnancy interruptions.

While such aetiological manipulations happen everywhere, they become of specific relevance in urban zones, where pregnancies are from the outset surrounded by

more ambiguity and mistrust. Since fertility is often not the primary aim in relationships, since multiple alternative aspirations and loyalties are present, and since abortion methods are generally more easily known and accessed in town, the possibility that an interruption might in fact be induced by the woman herself is, if not explicitly acknowledged, always implicitly suspected. This is not to say that women necessarily abort their pregnancies more frequently when they have urban aspirations and lifestyles than when they do not; rather, it demonstrates the degree of distrust characterizing interactions between partners who find themselves in a zone of multiple horizons. This distrust, inspired by the uncertainty about a partner's reproductive goals, blurs the question of intentionality even more; when *pregnancies* are not clearly (known to be) 'wanted' or 'unwanted', their *interruptions* certainly occupy a grey zone between 'wanted' (i.e. induced) and 'unwanted' (i.e. spontaneous) extremes. Reproductive interruptions thus confirm *and* exacerbate the distrustful ambiguity that surrounds fertility matters in urban zones offering alternative aspirations to men and women alike.

This heightened ambiguity is not always disadvantageous. It can offer both partners room to negotiate their stakes in the social situation at hand. While the *acknowledgement* of this grey zone makes threats before possible interruptions more effective, its *actuality* afterwards creates room for the manipulation of others' suspicion or for the tactical appointment of aetiological explanations. The indeterminacy of the causes and consequences of pregnancy interruption makes the vital conjuncture around the event one in which many outcomes are possible and different directions can be taken. It is here that women in particular have space to bring its course in line with their aspirations – urban, marital, reproductive, or other. As Piot (1993) has argued in his study among the Kabre in Togo, ambiguity, as part of a cultural repertoire in daily life, allows for individual strategizing. In agreement with Comaroff and Roberts (1981), who write about the dynamics in Tswana disputes, Piot states:

> It is precisely the open-endedness of the normative order that facilitates, indeed encourages, individual strategizing and mobility in the everyday. Playing off of the ambiguity inherent in experience, Tswana disputants construct competing interpretations of events and thereby attempt to enhance their positions in hierarchies of power and wealth (1993, p. 356).

However, not everybody can turn this ambiguity to his or her hand; certain forms of capital and other conjunctural circumstances define which options are available or attractive at certain points in time. The last section of this chapter will explore Sophie's room for manoeuvre, and relates this to the pathways and projects that she encountered and envisaged in life.

Ambiguous ambitions: Sophie's experiences reconsidered

While the previous sections have depicted possible marital and reproductive options for Gbigbil women with urban aspirations, particular forms of fertility management can only

be fully comprehended when situated within the specific vital conjunctures and webs of relationships in which they occur. Contrary to a common depiction of urban women – or women with urban aspirations, for that matter – as individuals having required a certain independence in (reproductive) knowledge and decision-making, and therefore being predictable in their behaviour,[36] I agree with Bledsoe et al. (1999) that also for them 'a certain fertility dynamic has been set up well before the women themselves take any reproductive decisions'. Which fertility dynamic had been set up for Sophie, then, and how can we make sense of her navigation of the different reproductive conjunctures in her life?

As Sophie was born as the third child of the fourth – and youngest – wife of her father, many siblings (from different mothers) had preceded her; most of them had already borne children as well. Motherhood was therefore not presented as a priority for Sophie; since the *quartier* was already full of descendants and her relatively wealthy and educated father aspired to alternative futures for his children, she was neither expected to bear children for her own lineage, nor obliged to quickly do so for a family-in-law. Sophie's mobile lifestyle, exposure to urban influences, and attendance of different schools during the years in which she was fostered by her sister further enhanced an image of future womanhood inspired by ambitions beyond those of rural production and reproduction. Motherhood and wifehood were thus not only potentially postponed, but also made part of a larger repertoire of projects. This amalgam of aspirations offered Sophie room to negotiate different ambitions and interpretations regarding the role of fertility and marriage at certain points in her life.

Her two premarital pregnancies were associated with very different interpretations of motherhood. Initially, the pregnancy conceived in the informal 'friendship' with the father of her first child was anxiously equated to motherhood and marriage with a *va-nu-pieds* – both of which were considered final obstructions to a still hoped for future educational path. The failure of Sophie's abortion attempt and the influence of her parents, however, led to a reconceptualization of the implications of this pregnancy; stressing the temporary character of pregnancy and nursing, all of them rather minimized the consequences of childbirth for other future projects. In the face of alternative aspirations they concluded that now was not the time to become a (socially recognized and enacted) mother or wife: neither the present circumstances nor future images suited that. 'Pregnancy is one thing, motherhood another' (Paxson, 2004, p. 123).

Another notion of motherhood suddenly appeared when Sophie conceived with her husband-to-be Alain. Despite her initial abortion considerations, the wish for children of both Alain and his family made her reconsider the value of this pregnancy in the absence of any other hopeful horizons for the future. After all, with his salaried job as a teacher, Alain was a good 'fish' to catch. The pregnancy suddenly turned into a means to bind an influential man to Sophie and enable her to still attain a form of urban respectability – a project that had become increasingly endangered by the sickness and

financial shortcomings of her father. With the willingness of her in-laws to initiate bride-price payments and the approval of her family, Sophie went into marriage after the birth of her second daughter. This is not to say that her previous ambitions related to educational and personal development had disappeared; rather, these were put in a different time-frame. Instead of postponing motherhood for the sake of education, this unanticipated marriage situation made Sophie postpone her educational ambitions for the sake of motherhood. Her priority was now to give some children to this 'big fish' who seemed desperate for offspring, in the hope that it would offer her marital respect and financial security (especially through a marriage certificate), as well as the possibility to continue schooling afterwards.

These ambitions were altered again when conjugal conditions worsened and promises of urban respectability (as the only wife of a 'big fish') and financial comfort (through a legal marriage) vanished. Anger about a sudden unfaithfulness and the neglect of expected duties by her husband pushed Sophie to take 'revenge' by also depriving Alain of what he expected from her: children. Her repeated stance that 'I don't refuse to give children, but I won't give them in such a situation' transforms a married woman's duty to bear children for her husband into a *conditional* one. Even if the timing and her social status as a wife would allow for, and even encourage, motherhood, the mere *context* of marriage was not enough to make Sophie unconditionally adhere to the childbearing norm; the *content* of the relationship – suddenly characterized by distrust and disappointment – also mattered to her. The possibility to make such a firm fertility-related resolution seems based upon several forms of capital that she possessed. After all, she had borne some healthy children for which she knew Alain was longing, she had found alternative lovers who could financially maintain her, she had a safe haven in the village where her mother and sisters would allow her to come and 'take rest' whenever she wanted, and she had an educational basis which would, even in the absence of a marriage, allow her to search for employment and thus an alternative source of urban honour.

Yet, over time, most of these alternatives seemed less advantageous than anticipated. Acknowledging that support from her own kin had become limited since her widowed mother resided with her own family, that relationships with outside lovers were not able to give her the long-term prospects that she could find 'inside' a marriage, and that she could only draw on her dactylographic knowledge if she owned a typewriter, Sophie turned her fertility into a horizon again: as her co-wife had remained childless, conception would revive Alain's (and his parents') interest in her and assure her re-entrance into marriage and her restoration of urban respectability. Such sudden changes in perspective show the importance and complexity of conceptions about the 'right' timing of childbearing, motherhood, and wifehood, and how these are negotiable and changing – contingent on previous pathways, present circumstances, and projects for the future. While a similar argument has also been forwarded by Johnson-Hanks (2002b,

2005, 2006, 2007) with regard to *entry* into motherhood and wifehood, Sophie's case shows that the 'indeterminacy and innovation' of which Johnson-Hanks speaks extend *beyond* initial childbearing and marriage. Indeed, since, according to Johnson-Hanks, it is women's aspirations that inform the appropriateness and appreciation of pregnancies, it is not surprising that women with multiple but uncertain urban aspirations – which might switch to rural projects again at any point in time – constantly shift their notions of the right timing for motherhood and wifehood throughout their entire life course.

Shifting fertility aspirations also underlie Sophie's management of her two pregnancy interruptions. These happened in two completely different social situations. In the first instance, Sophie had been the centre of attention of her promising husband and in-laws, who seemed able to offer her a comfortable urban lifestyle. Becoming pregnant in this situation was desirable; a pregnancy interruption instead raised suspicions of induced abortion – especially since everybody remembered the initial conflict between Sophie and Alain's childbearing intentions. In order to appease the distrust that now characterized the relationship with this 'big fish' who seemed worthy of clinging to, it was in Sophie's interest to externalize the cause of her misfortune by exploiting a 'neutral' aetiological discourse regarding the 'women's worm'. After showing her 'goodwill' and 'innocence' by killing the worm and conceiving again, the incident was soon disregarded; 'people didn't consider it too much, since it was a pregnancy of two months which contains only water'.

In the second case of pregnancy interruption, the situation was almost the reverse: Alain had turned his attention to another wife and no longer cared about Sophie's childbearing capacities; he neglected Sophie and her family financially; Sophie's ambitions of a future formal marriage had been destroyed by the coming of the new co-wife; and becoming pregnant was something that she initially had not hoped for. Her pregnancy interruption triggered an evaluation of – and was also interpreted in terms of – unmet expectations and rejected reciprocities by Alain. It touched on Sophie's marital insecurities as well as her reproductive (in)competence in the current conjugal competition. Not surprisingly, Sophie externalized the cause of the interruption and depicted herself as a sufferer again, but with totally different connotations: simplistic, naturalistic explanations – like the 'typhoid' diagnosis she received in the hospital – were no longer adequate but were replaced, or at least complemented, by personalistic accounts of the co-wife's witchcraft practices. These accusations and Sophie's active search for remedial counter-attacks show how the event became a trigger for Sophie to publicly denounce the insecure marital situation and to reassert her ambitions. What was at stake now was the preservation of the union with, and loyalty of, a 'big fish' – the only feasible horizon towards a restoration of urban honour.

Together with a shifting aetiology, notions of embryology shifted in such a way that this second incident became much more consequential. This time, what was lost in early pregnancy was no longer negligibly described as 'only water', but was considered a

potential human being and even Sophie's childbearing capacity in general. Yet, her repeated utterance of 'I will not bear any children anymore' remains highly ambiguous: it could indicate an undesirable consequence of affliction as well as a conscious decision to stop childbearing. Maintaining this ambiguity around the intentionality of her interruption allowed Sophie to strategically shift positions and power relations – sometimes lamenting a lasting dependence on others in marital and reproductive domains, while at other times asserting her 'fertility halt' to be a deliberate way of punishing her husband. Contrary to Yvette, who, in her deprived situation as described in the previous chapter, tried to downplay all ambiguity connected to her fertility interruptions, Sophie turned this ambiguity into a resource. Indirect allusions to induced abortion strengthened her demand for marital responsibility from her husband and in-laws; they were in turn strengthened by the presence of supportive family members as well as a record of successful childbearing and conjugal dedication.

Sophie's pregnancies and their interruptions were pervaded by changing and sometimes even contradicting feelings, rationalizations, and ambitions – even if her wider project of living in the city remained intact. The presence of alternatives and of different forms of social support and capital offered Sophie freedom for these interpretational shifts. Pregnancies turned from unwanted to wanted or vice versa; interruptions were sources of grief or relief. In the face of multiple, quickly changing, and often ambiguous relationships and horizons, Sophie's reproductive decisions were indeed 'bets' on an uncertain pathway to urban respectability.

Conclusions: negotiating hopes and horizons

This chapter has shed light on the sexual and reproductive navigations of Gbigbil women who, at some point in their lives, aim for a future in the city. In the face of alternative ambitions such as education or employment, the village ethics of production and reproduction cease to offer the only framework of respectability. Rather, formal engagements and childbearing are postponed, while premarital sexual encounters proliferate. I have argued that the volatility and pursued profitability of these relationships create a mutual distrust between men (especially the promising ones, called 'big fish') and women, while at the same time they may lay the basis for a future marriage – which, after all, remains an *ultimate* project in life.

Within these ambiguous relationships in which both partners have multiple ambitions, fertility is often a 'bet' that might either disrupt or stabilize an urban affair. Crucial in this bet is the notion of the 'right timing' of reproductive events. This notion is in itself contingent upon previous pathways and present projects, and subject to post-conceptional negotiation with many social others. As a result, pregnancies are rarely clearly 'wanted' or 'unwanted'; rather, fertility desirability is *temporal* (i.e. a pregnancy might be initially wanted and unwanted afterwards, or vice versa); *contradictory* (i.e. a

pregnancy might be wanted for one purpose and not for another); or *situational* (i.e. a pregnancy might be wanted with one man and unwanted with another). Contrary to what family planning campaigns and posters like the one shown in Figure 8 (targeting young educated women) presume, fertility desires are never stable, but – especially in unstable partnerships and during unstable pathways – change flexibly in accordance with one's hopes and horizons, and the negotiations thereof during reproductive conjunctures.

In the process of such pregnancy negotiations, the fate of a foetus becomes explicitly bargained – *foetal* bargains that might turn out to be *fatal* bargains, for the foetus or for imagined urban futures. The 'fall' of the unborn foetus can be either the *consequence* of relational uncertainties (in case of provoked interruptions), or the *cause* of further ambiguities (and possibly the end of an urban relationship) since it raises suspicions with regard to women's fertility desires. As the intentionality behind interruptions often remains indeterminate – especially when women (are known to) have unclear fertility aims or clear alternative aspirations – a strict divide between spontaneous and induced loss becomes blurred. This blurriness not only follows from, but also allows for, women's tactical deployment of existing aetiological notions, as well as other opportunities, to assure certain stakes. Contrary to the story of Yvette in the previous chapter, Sophie's case has shown how reproduction and interruptions can turn into opportunities to denounce certain circumstances and assure individual aspirations – especially when women possess different forms of capital such as a respectful background in the village, education, employment, childbearing capacities, or living children.

As previously stated, the distinction between this and the previous chapter is not one between different types of women; rather, both chapters have focused on different projects that women may pursue at different points in their lives, and the ways in which these projects are at stake when previous pathways possibly derail due to pregnancy interruptions. Both chapters have shown the amalgam of horizons and new aspirations that may appear in vital conjunctures happening on different pathways, and have analysed *why* women might prefer to explore one or the other. The next chapter will continue to focus on this reproductive navigation, but with a different question in mind: it sets out to describe *how* women make, negotiate, and justify their navigational choices within the particular webs of social relationships in which they are embedded. It will show that, irrespective of their particular trajectories and choices, women often have a common way of portraying their projects to those that surround them – with paradoxical effects.

5. HANGING UNDERWEAR AND FALLING MANGOES: ON IDIOMS OF DISTRESS, DESTINY, AND DECISION-MAKING

Today, all or almost all girls can go to school. So they think, they believe, that they will be better able to direct their destiny. That they will be able to choose, finally tell men what they never could or dared to tell them. (…) But they just don't understand that that won't work.

- Marie-Félicité Ebokea, '*Femmes fragmentées*' (1994, pp. 25-26, my translation)

There exists a contradiction between the theory that women have no voice and the fact that some of them 'speak'…

- Philippe Laburthe-Tolra, '*Mínlaaba*' (1981, p. 900, my translation)

The previous accounts of Yvette, Sophie, and many others have shown the various ways in which Gbigbil women manage their reproductive interruptions within different social contexts and with different aspirations in mind. The particular make-up of previous pathways and of possible projects has been shown to affect the navigation of vital conjunctures around pregnancy interruption. This chapter aims to look *beyond* those particularities and shed light on some general discursive devices that women deploy in their reproductive navigations – irrespective of which direction they want their pathways to take, which hopeful horizons they wish to explore, or which personal projects they aim to pursue. It explores not *why* they make particular choices, but *how* they go about framing, asserting, and justifying these reproductive decisions within the social worlds of which they are part. As such, this chapter aims to unravel broader patterns of interaction between individual women and their social surroundings, and the ways in which these interactions evolve around or even 'optimize the occurrence of promising novelties' (Guyer, 2005, p. 379) during reproductive conjunctures.

Central to this chapter are the shared idioms of distress, destiny, and decision-making that women draw upon during their reproductive navigations.[1] These local perceptions and portrayals of suffering and agency not only shed light on the common pool of navigational tactics deployed by women with different reproductive experiences and aspirations; they also question theorized assumptions *about* this navigation – and the suffering and agency that supposedly direct it. First of all, they question the application of the suffering-agency divide to forms of interrupted fertility: namely, the association of

spontaneous loss with suffering and induced abortions with agency. Second, they challenge prevailing discourses of modernization and empowerment, which portray rural women as merely powerless and their urban counterparts – or, those with urban ambitions, for that matter – as powerful.

The stories of a village *mama* experiencing secondary infertility and of a young, educated, and urban-centred woman attempting to abort several pregnancies serve as a starting point for this chapter, because they would, according to the above assumptions, represent clear instances of suffering and agency respectively. However, I will throw a different light on this supposition by illustrating how both women use images of power and powerlessness in a similar way – despite their different pathways, pregnancy-related experiences, and projects. Further, as the two cases could be considered two extremes on a 'reproductive continuum', the analysis will form a starting point to generate more *general* insights about reproductive navigation and the ways in which (inter)personal dynamics affect its outcome – something that will be discussed more elaborately in the conclusion of this dissertation.

Hanging underwear: mama Rosie's story

Mama Rosie is one of the most prominent *mamas* in Asung; it is difficult for both outsiders and insiders to ignore this woman with her heavy body and loud voice, who lives right in the centre of the village. Her slow pace caused by painful and rheumatic knees stands in shrill contrast with her quick uptake of, and eager participation in, multiple activities in the village. As the *présidente* of the women's association *Seying Inīng* ('We search our lives') she is the first one to inform and organize women around crucial events in Asung and its surroundings;[2] as an *agent de santé* she is a regular visitor of all households in order to measure and promote mother and child health;[3] as an in-married wife in Asung she is renowned for her performances during village palavers and funeral ceremonies;[4] and as my 'adoptive mother' she offered me delicious meals and secret knowledge on a daily basis. My regular presence in her household allowed me to witness first-hand her personality, problems, and actions; our frequent conversations introduced me to the circumstances, worries, and decisions that had happened over the past fifty-two years of her life.

Unlike her complaints regarding her current marital situation, mama Rosie's stories about her past are pervaded by good memories of the polygamy she was born into, in a Maka village some forty kilometres from Asung. As the third child of the second of her father's three wives, she grew up in an extended family in which 'you could not know who was the mother of which child, because no distinctions were made'. Things changed, however, after her father died, when mama Rosie was eight years old. Her mother left the marriage and remarried soon afterwards. Only the first wife – taken through levirate (widow inheritance) by her brother-in-law – stayed in the compound,

taking care of the thirteen children of her deceased husband. The resulting 'suffering', as mama Rosie calls it, induced this *maratre* (the co-wife of her mother) to write a letter to her former co-wife to convince her to come back and take care of her own five children, amongst whom mama Rosie was the only girl. Life became good again for mama Rosie; with not only her mother(s) but also many older brothers around, she was well taken care of and sent to primary school and the Catholic *école menagère* – although with a serious delay because of the afore-mentioned familial problems.[5]

It was only at the age of seventeen that mama Rosie started to menstruate. Freed from her worries about the absence of a normal menstrual cycle, she now initiated a sexual relationship with a primary school teacher who had been pursuing her for some time. After she had 'started to like the taste of it', as mama Rosie smilingly tells me, she neglected her schooling and engaged with Etienne, the son of the village catechist. The true 'love relationship' which developed between them made him initiate bride-price payments, whereupon she moved into his house. 'I thought that this was the man whom God had given to me', mama Rosie admits with some regret in her voice. However, Etienne's mother, who argued that it took too long for mama Rosie to conceive with her son, opposed the relationship and proposed an albino girl who had already given birth elsewhere. This proposal was met with resistance; Etienne fled the village by joining the army, while mama Rosie's family members came to take their daughter – now exposed to the bad behaviour of her mother-in-law – back home. Nevertheless, the two lovers continued to write and occasionally meet in secret.

During Etienne's absences, mama Rosie engaged in sexual relationships with two teachers at the same time, Bernard and David. She conceived with Bernard at the age of twenty-one and rejoiced in the fact that, four years after the onset of menstruation, she had finally become pregnant. Bernard, however, left the village for a position elsewhere soon after mama Rosie had discovered her missed period. Etienne also put an end to their secret relationship as soon as he detected the pregnancy, and took another wife who turned out to be mama Rosie's maternal aunt – despite the claim of his mother that he must be the father and should take mama Rosie back into marriage. Although this marriage proposal was explicitly declined by mama Rosie, now that her kin resided in his house, the claim of Etienne's paternity was not. 'What could I say? Since we are in the same village, they could do wrong to my child if I would have said that it was not his. It is only God who knew to whom the child belonged'. Since the biological father had disappeared and Etienne was engaged in a new marriage, mama Rosie decided to also tell her other lover David that he was the father. 'I had to cling to somebody who could endure me with my pregnancy'. David was willing to engage and came with the layette after the birth of mama Rosie's son. His marriage proposal was nonetheless again declined by mama Rosie; 'I didn't want to marry anymore, because my first husband had deceived me and the father of my child had deceived me as well'.

Thus disappointed by men, mama Rosie started to focus on her work in the fields, petty trade, the care of her son, and her work as a housekeeper at the Catholic missionary station in Abong Mbang, a town some fifty kilometres away. Here, she continued her choral and catechist activities in the Catholic Church that she had initiated at a younger age, while she also earned a bit of money. 'I provided for my own soap and didn't think of men anymore. What can men offer me more than what I offer myself with my own hands?' Nevertheless, three years later, papa Gerie convinced her to come into marriage in Asung. He regularly visited his classificatory brother who worked as the *Chef de Poste Agricole* in mama Rosie's village, and was a descendant of the rather influential Bibakung family in Asung – thus known to and recommended by mama Rosie's aunt, who had gone into marriage in Asung. Having one son and one daughter from a deceased wife, as well as two daughters with a wife 'who showed small weaknesses in her habits', papa Gerie was searching for a new wife 'who would be able to cook for me', as he recalls to me later. After some doubt was removed when papa Gerie agreed to take care of her son and to transfer presentational gifts to her family, mama Rosie finally decided to 'go and see'.

Her arrival was met by the enormous resistance of her co-wife mama Cathérine. Mama Cathérine, heavily supported by her mother-in-law who originated from the same natal village and who had arranged her marriage with papa Gerie, accused mama Rosie of using indigenous remedies to take away her husband's love and her own position as a first wife. Many public judgments ensued in which papa Gerie's influential and respected older brother Albert – functioning as advisor (*conseiller*) and deputy mayor (*adjoint maire*) at the municipality of Bélabo – tried to ease the conflicts between mama Rosie on the one hand, and mama Cathérine and his mother on the other. Both in these *assises* and in her conversations with me, mama Rosie portrayed herself as a good-willing daughter-in-law who passively suffered the whims of her co-wife and in-laws. Her fertility problems reinforced this image of suffering:

> My problem is a bit difficult to understand. I entered menopause at the age of twenty-nine, after four years of marriage. Before this menopause, I didn't feel any pain in my belly. Nothing. But then my menstruation suddenly stopped. You should have seen my breasts! The milk was even flowing. One would say that I was pregnant. Mama Cathérine started to fear that if I would bear a child for her husband, she would lose her place. She started to talk everywhere. But the pregnancy didn't come out [*la grossesse ne sortait pas*]. Only the breasts. People mocked with me and especially my co-wife's family accused me of inventing a pregnancy. Others suspected me of having aborted the pregnancy. I went to the hospital in Bertoua. They injected things to induce my period. When it didn't come they told me to wait a bit longer; they were not sure it was a pregnancy. I even went for an ultrasound in Ngaoundéré [capital of the Adamaoua Province]. They told me that I don't have a problem, that I should normally menstruate. They advised me to visit the traditional healers, because this was not at their level. And the traditional healers said that it is mama Cathérine who has blocked my menstruation. That she has taken my underwear stained with menstruation blood and attached it somewhere through witchcraft, so that I would not conceive anymore. That she is afraid that her husband wouldn't pay attention to her anymore once I would bear children. Really, I suffered a lot. But what could I do? I was only lucky because [my in-laws]

> have seen how I had first given birth. So I was not sterile. I arrived here when my child was three years old. Of course this didn't mean that I shouldn't conceive from papa Gerie. But people couldn't really talk about me.

Whether in-laws and villagers *did* talk negatively about mama Rosie's childlessness or not at that time remains unclear; but surely mama Cathérine *was* put in a bad light by the accusations of different *marabouts* and mama Rosie. According to the latter, the accounts of hanging underwear were even confirmed by villagers who had seen her co-wife visit local healers to 'attach remedies' – something which was eventually publicly confessed by mama Cathérine.[6] Mama Rosie thereupon stopped searching for treatments, since nothing had ever worked and her husband had reassured her that he could not refuse her because of her childlessness:

> I told my husband that I couldn't search anymore. I leave everything up to God. My life is in His hands. If it's God who made it stop, I will endure. If it's my co-wife, God will judge her. Because God himself has wanted people to be fertile and to multiply, so it should not be blocked by others. But since I had love for my husband and he took care of me… If I took the decision that I would make remedies to kill her, these remedies would not only kill her, but a lot of innocent people as well. I have been baptized and I cannot kill. I have love for God. And I have a heart of pardon.

This heart of pardon was, however, questioned by many outsiders, who were prone to recall the serious problems mama Rosie caused when papa Gerie took a third wife a few years later. Many stories recount how mama Rosie wanted to kill this co-wife with a machete and was sent back to her family – after years of marriage that had in fact *always* been pervaded by struggles and fights. Mama Rosie, who had initially hidden this incident from me, admitted the case when I asked her about it; but rather than elaborating on the exact cause of the separation, she focused on the reunion with her husband one year later – interpreting his demand for reconciliation as a sign of her own worth and indispensability within her family-in-law and the wider village. Encouraged by her relatives and this idea of personal significance, she had firmly decided to 'regain my place in marriage and never leave again'.

Indeed, her immediate accusation of harassment by mama Cathérine and the new co-wife, both before and during her absence, helped her to re-establish herself; it eventually led to the departure of the third wife, as well as papa Gerie's refusal to have sexual intercourse with mama Cathérine – who had just given birth to her fifth child – for the rest of his life. The situation improved for mama Rosie; after some time, papa Gerie even married her officially. Who exactly initiated the request for a formal marriage – papa Gerie, mama Rosie, or mama Rosie's brother – and whether mama Cathérine also obtained a marriage certificate, remains contested. According to mama Rosie, it was papa Gerie who wanted to consolidate their union and, in order to prevent problems, proposed a formal marriage to his first wife as well.[7] However, in contrast to mama Rosie's own relatives, who considered the *acte de mariage* as a source of security for their daughter

who had remained childless in this marriage, the family of mama Cathérine had refused to sign the certificate as long as the bride-price for their fertile daughter was unpaid – thus leaving mama Rosie 'the only wife in the household with a marriage certificate'.

Although the lack of an *acte* for mama Rosie's co-wife is denied by papa Gerie and mama Cathérine herself – both claiming that a marriage certificate *does* exist – what is clear is that, over time, mama Rosie's position in the village and family-in-law solidified, while mama Cathérine's condition gradually degraded to a situation which was openly pitied by many villagers. Looking dirty and angry, walking barefoot, dressed in old rags, never going to the fields, rarely preparing food, and always carrying around her mentally retarded granddaughter who was allegedly 'spoilt' by witches, she was said to 'have no voice anymore' and believed by some to have been mystically 'destroyed' by mama Rosie. Although she did not directly invoke suspicions of her co-wife's witchcraft herself, mama Cathérine acknowledged her downfall when I succeeded in talking with her about her current marriage – which was often impossible due to the physical presence of, or my symbolic association with, mama Rosie. Somewhat guardedly, she declared:

> I don't like it. I had everything. When he was a driver of the Ministry of Justice, my husband wasn't poor like he is now. When a second wife comes to spoil the marriage, it is never good. But there are already children and I wanted children. Rather than to leave, I stay. People would say I'm not even here. I only watch everything with my eyes, I take care of my children, and wait for my grandchildren. You need patience in polygamy. If another woman enters and you see that she has a high heart [*un coeur haut*], you should only lower [*abaisser*] your own heart. You should stay calm while the other speaks loudly. It doesn't make sense to insert your own mouth as well. Only patience can create concord.

Others admitted more openly that my 'adoptive mother' was considered a great witch in the village – for many reasons. First of all, mama Rosie's lack of children and absence of a normal menstrual cycle were considered suspect; 'maybe it is because her witchcraft eats all her blood inside', some informants speculated. Second, mama Rosie's 'power to speak' while she had rendered her co-wife mute must have been a result of her occult powers. Third, papa Gerie's preference for his infertile second wife over his fertile first wife must have been engendered by the former's malevolent use of remedies. And finally, even my daily interactions with her were interpreted by some as a sign of the mystical powers she had exercised over me. Mama Rosie never contested this powerful image, or the fact that her co-wife was worse off than herself; she just explained it in a completely different way:

> I always knew that God would punish my co-wife. And there she is now, punished by God. It is difficult for her to even have five francs or one piece of soap. For more than five years, she hasn't been working in the fields. And I, I help myself. Even if I'm ill, I go to the fields. It is me who feeds her children every day. And these children come to me as well; they fetch water, they search for wood, they do everything for me. I leave everything up to God. But I know I also have this power which my family-in-law gave to me. The women who firstly arrived as wives in this family have a lot of power because they are the eldest. They are able to give me respect and dignity and power if they want. With their own power they can tell me, 'I was the

> first to arrive here and I give you my power to govern'. That's what they did. They appointed me as a president of the women's association. They gave me a power which makes all people listen to me when I speak. And next to these women, there is my brother-in-law Albert. When I arrived here, I gave him a lot of respect. I always gave him the first products of my field [*tjəng*].[8] When I did this, he gave me 1,000 francs and told me, 'Even if I die, you will always govern my *quartier*'. So that's why, even if there were problems with my husband, Albert always wanted me to stay and blamed my co-wives. Because he had already appointed me as the governor of his *quartier*. It followed from my good behaviour. Albert always said that I am the one who helps to raise the children. I am hospitable to the visitors. I have good habits. I prepare a lot of food. The whole family eats. So I am a wife of the family. And it is the work that you do in front of the people and your husband that makes a marriage and that makes you a woman. Even if you don't bear children.

Thus confirmed by official and unofficial acknowledgments, but also contested by many villagers, mama Rosie's powerful position had always been surrounded by ambiguity. The sudden death in 2007 of her thirty year old son, who had lived with his biological father Bernard in a coastal city ever since Bernard had come to claim his child, exacerbated this insecurity. 'Formerly, I knew that if somebody insulted me, my child was alive and would come and defend me at a certain point. But now, even if somebody wants to hit me, who will respond for me in the place of my son?' That there was much more to it than only physical defence became clear to me during a chat with my informant Laura, her father, and her blind uncle (a preacher of the Jehovah's Witnesses) one afternoon. While discussing general problems of polygyny, these neighbours and classificatory brothers of papa Gerie started to denounce mama Rosie's behaviour as they had witnessed and interpreted it over time:

> *Father*: Their marriage certificate was even signed in secrecy after mama Rosie had asked for it herself. Imagine! And afterwards, papa Gerie said that, since his own children do not [officially] belong to him, mama Rosie's son will be his heir.
> *Laura*: And now the child is dead.
> *Uncle*: A deception created by God. God has seen that if He would leave things to happen, it would end very badly.
> *Laura*: God doesn't forget anybody. You do your things and think you have won, but you don't know what will happen to you later.
> *Uncle*: To the contrary, you will lose.
> *Laura*: She has lost. She doesn't even have any grandchildren. Mama Cathérine's children will stay with the wealth of their father. Mama Rosie wanted to take this, but she hasn't succeeded.
> *Uncle*: Rosie doesn't even have any right to speak if papa Gerie dies.
> *Laura*: She really doesn't. Government is government; family is family. The family will decide. And the government cannot do anything at this level. They don't know anything; they can only hold a pen and write. But we, here in the village, we know everything. Who will accept her?
> *Father*: A woman who leaves her own village to come and dominate another village…
> *Uncle*: It's the force of remedies! She is a bad demon – a real Satan.
> *Laura*: And that's how it is with many people who say they love God. People who are frequently in the church, are often the greatest witches. We're afraid of her. And therefore, she's all alone. Eke.

Like many other villagers, these three neighbours pointed to mama Rosie's increased insecurity with regard to her inheritance rights. Now that mama Cathérine had one son and mama Rosie had none, the latter would, even with a marriage certificate that she claimed her co-wife did not have, possibly encounter problems upon her husband's death. The recent deaths of all of papa Gerie's siblings, as well as his eldest son, made the question of inheritance even more pressing, and radically altered the prospects and positions of both co-wives. To be sure, mama Rosie was both literally and symbolically one of the biggest *mamas* in the village now; surrounded by many foster children, namesakes, and people demanding her advice during my evening meals in her *hangar*, she would proudly state that she was 'the mother of everybody' or would be called 'my wife of *ambiance*' by papa Gerie. However, whether this *ambiance* will continue after his death, is something 'only God knows'.

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In many ways, mama Rosie's story reveals dynamics and contingencies that have been discussed in the previous chapters – with her particular pathways and projects directing her particular reproductive and marital decisions. But the way in which she *talks about* and *justifies* these decisions is more than only particular; it also appears in the narratives of many other Gbigbil women – even those with more room for reproductive decision-making or with alternative (urban) ambitions. All of them invoke suffering and agency in similar ways; mama Rosie's story is, contrary to what one would maybe expect, not more about suffering than theirs is about agency. There seems to be a common narrative framework that is drawn upon by women with different social and educational backgrounds, different reproductive experiences, and different ambitions alike.

To shed light on this narrative repertoire I continue to present the story of somebody who can be considered mama Rosie's opposite: Laura. As a young educated woman aborting pregnancies while building up a life in the city, her life course and conditions are clearly dissimilar from those encountered by mama Rosie. Yet, the framing of her reproductive experiences is not. Her story will therefore allow for the exploration of common languages of distress and decision-making that pervade and direct women's navigations of a variety of reproductive conjunctures in completely different social situations. This, in turn, will shed new light on common assumptions that portray infertility in a patrilineal village in terms of suffering and that celebrate abortions of urban women as proofs of autonomy, empowerment, and resistance against the existing order.

Falling mangoes and falling foetuses: Laura's story

It is a chilly morning in August 2009. After an icy trip on a motorcycle taxi, which brought us to the city centre, I descend from the vehicle together with my informant Laura, who wears a blue dress with a pink flower print, and carries a pink handbag. We quickly enter the labyrinth of unpaved paths in the neighbourhood where we have an appointment with a mutual acquaintance. Laura quickly reciprocates greetings from others, but leaves questions about our direction unanswered. I ask her whether she feels nervous; her answer is negative. Upon arrival at our destination, we find that the man in question has unexpectedly left his house – which from the outside looks so similar to all the other houses in this slum area. While waiting for him, we watch – together with some children, patients, and neighbours – a popular soap opera on TV. Laura, like the others, reacts animatedly to the plot of a certain Anita trying to spoil the marriage of her lover Deniz. She seems to feel more comfortable than I do. Her relaxed attitude changes a bit, however, once our acquaintance enters the room after an hour. He puts on his white coat and invites us into his small consultation room, which is only separated from this living room by an old, torn curtain. Laura takes a seat on the only chair in front of a desk, while I install myself on a low wooden bench placed
against the mud wall of this small, dark room.

Although we are both acquainted with this doctor, our conversation unfolds in an atmosphere of unease. With her head leaning on her hands, Laura declares that she missed her period. The doctor asks whether she has already done a pregnancy test. Laura takes a small jar filled with urine out of her pink bag and places it in front of the doctor, asking him whether it could be done now. After the transaction of money for the test, which needs to be retrieved from some unknown source in the city by a young male assistant, and more soap opera drama for Laura and me while awaiting his return, Laura's fear is confirmed when the doctor shows us the two blue lines which clearly appear on the urine-drenched strip. He starts to pose several questions about Laura's menstruation, reproductive history, and the moment of conception – as I have heard him do when I accompanied other informants before. He concludes that Laura's pregnancy has attained eight weeks, and explains that an interruption will therefore require two phases: one in which the foetal tissue will be purposefully damaged, and one in which curettage will be performed. In between these interventions, Laura will have to go back to the village and wait for the blood loss to commence and gradually intensify. Laura agrees. She stresses that whatever the proposed treatment is, she will undergo it. After some financial negotiations, a deal is made for at least the first part of the intervention. We are asked to return towards the end of the afternoon, when all the other patients will have left.

And so we do. Laura is immediately asked to undress and to climb upon a table. She removes her underwear but keeps her flowered dress on. The doctor opens a wooden window to let in some light and fresh air. Few words are exchanged. The next few minutes are filled with only the sounds of the doctor's metal instruments, the

dripping of Laura's blood from the table into a bucket on the sandy floor, and the voices of playing children in the courtyard outside. Laura keeps silent, but has her mouth wide open in order to breathe in and out deeply. She covers her face with her left arm. Suddenly a considerable blood clot appears on the table in between Laura's legs. The doctor examines it, removes the speculum from Laura's vagina, and gives her an injection in her upper left leg. He orders her to descend. While she stands in front of me, silently raising her dress to let the doctor clean her genitals and legs, I ask her whether she feels okay. She points towards both sides of her belly: 'my fallopian tubes'. The doctor does not react; Laura silently puts on her underwear and picks up her pink bag.

Armed with a prescription for antibiotics and clear instructions as to the expected process and the envisaged return for curettage, we leave the room a few minutes later. Laura immediately starts complaining about how this abortion was much more painful than the others she underwent, but firmly states that she will endure all pain from now onwards. She doubts whether she will go back for the required curettage, especially since financial means are lacking. She does not even have money for sanitary towels and the required antibiotics – which, after our return to the village, appear to be out of stock in the health centre anyway. When I visit her in the evening to give her my own sanitary towels and some antibiotics, she immediately takes me inside her mother's dark kitchen where she is preparing a vegetable sauce that will be served with *couscous.* For a second time today, she lifts her dress in front of me – this time to put a sanitary towel in her underpants on which some first drops of blood are already visible. While pulling up her underwear, she whispers with a mixture of doubt and relief, 'We will see what will happen now. Since my blood is very strong, it often has difficulties to release. My pregnancies don't fall quickly…'

In the days that follow, Laura suffers from constant abdominal pain but loses no blood. Hidden in her dark bedroom in order not to attract people's attention, she is only visited by me and her mother, who offers her indigenous remedies to quicken the 'fall of the foetus'. During the many hours that I spend by Laura's side on her bed in the dark room, she reconsiders the previous abortion attempts she had undertaken, and always shared with me, from the very moment I had met her – some five years ago now. Indeed, during my first fieldwork period in 2004, Laura had been the only informant who had openly stated that she *herself* had tried to abort the pregnancy with which I had found her. Most other informants, still in the process of becoming acquainted with me, had only talked about induced abortions in hypothetical terms. But with my age-mate Laura – twenty-one years old back then – things had gone differently. She immediately shared with me how she had been made pregnant by Omar, a Muslim from the North of Cameroon, while she followed a full-time sewing training at the Women's Empowerment and Family Centre (*Centre de Promotion de la Femme et de la Famille*) in Bertoua.[9] After having been pursued by Omar for two years, Laura had 'fallen in his trap' by accepting his money and cooking for him in exchange. Despite her fear which followed a forced

defloration during one of these encounters, Laura – encouraged by her friend's words that 'it hurts for all women' – had returned to Omar and invested the money she received from him in her education. Not long afterwards, however, she conceived a pregnancy with Omar:

> I went to him because they had asked for money at school and I wanted him to help me out. He didn't want to give me his money. Instead, he asked me for love [i.e. sex]. I refused, since I was in my period of ovulation. Then, I asked him to protect himself. He refused as well. He said he would not use condoms with me anymore. Whatever I did, he wouldn't protect himself. Well, I thought, 'Leave it then'. The pregnancy has entered.

Immediately after the intercourse, Laura started to regret her negligence. Fearing that a pregnancy might interfere with her sewing training, she asked her schoolmates how to get rid of this accident. She used everything she was advised to swallow, insert, or purge: *nivaquine* pills, salty water, *Nescafé*; nothing helped. That same month, she left to Asung to spend the holidays with her parents. Leaving a letter to Omar announcing her pregnancy and abortion plans, she continued to take remedies upon her arrival in the village. Her practices were, however, soon detected by her mother mama Denise, who, upon hearing the news of a probable pregnancy with Omar, agreed with her daughter's abortion attempts. 'My mother was afraid of the reaction of my father, she didn't like Omar at all, and she wanted me to finish school first', Laura states. No blood loss was achieved, however, and Laura started to feel ill instead. In the village hospital where her mother took her, her activities were soon discovered and heavily reprimanded by the doctor. 'He told me that my blood was dying already and I should stop immediately'. He gave her injections to prevent the pregnancy from leaving.

Mama Denise, whether convinced by the doctor's warnings or afraid to reveal her own complicity, started to publicly scold her daughter as well. 'I told her there is her own body and there is a growing child in her body, and that I didn't want to lose any of these two!', mama Denise recalls to me later. She insisted that Laura should keep the pregnancy and give the child to her instead. Since mama Denise herself had only one daughter and two sons, and had experienced three additional reproductive mishaps, she would consider this first grandchild as an extra child for herself. This proposal made Laura furious; it had gone against all her expectations that her mother had in the first instance *agreed* with her abortion attempts – and even more that she now wanted to claim 'the child she had refused from the very beginning'. Nevertheless, Laura quit her abortion attempts. As much as this decision was inspired by her mother's change of heart, it was also related to other reasons:

> My friend had reminded me of something. Pope John Paul II had come to Cameroon once. He said that all Cameroonian women who try to abort their pregnancies in this country should die.[10] My friend asked me whether I had forgotten about this curse. I thought, 'What have I done? Will I die like all the others?' Initially, I had thought that God would understand my situation, but now I got afraid of the Pope's curse. And I started to think of a friend of mine, who always told me she would not bear a child since she was still young and wanted to play

> life. And then she died during an accident. She didn't leave a child whatsoever. So I thought, 'If one day I will also encounter an accident, I will just die like that. My mother will lose a lot indeed. It's better to leave at least one child behind who will remind people of me. And imagine that this first child that I want to abort is the only one in my belly, what will I do if I will never bear children again? Or if all other children who would follow will get angry because I abort this first pregnancy? They will flee and they won't come back. I might not bear any children anymore. No, even if my school will stop here, it is also good to have a child'. So I decided that, even if everybody hated my pregnancy, I would keep it. I was curious to see what God had envisioned for the child.

Mama Denise's proposal that Laura give this child to her – which was gradually supported by Laura's father and two brothers – remained heavily contested by Laura. Her argument that she could not leave her child in '*la souffrance*' of her family's poverty led to the indignation of her father and older brother, who had always borne the burden of financing Laura's training in Bertoua. 'We walked barefoot here in the village to send our children to school, and then we were reproached for being poor; it made me very angry and especially my eldest son also blamed his sister', Laura's father admits to me. While the two men stopped their financial contributions to her education, Laura's relationship with mama Denise also rapidly deteriorated 'until we even seemed to be co-wives, since we didn't talk to each other anymore'.

It was after these failed abortion attempts that I entered the field for the first time, and approached Laura who was by then visibly pregnant. Fed up with the tensions within her family, she immediately told me the whole story and announced her plans to flee from the village. And so she did – but not without giving me clear indications of where she would reside in Bertoua. When I visited her a few weeks later in the indicated house of her classificatory maternal aunt, Laura told me how Omar had become furious upon discovering that she had *not* aborted. In fact, an abortion would have suited him, since he wanted to invest his money in the house he was building, and not in a girlfriend and a child. Laura, in turn, asked him for 25,000 CFA Francs (around 38 Euros)[11] which she claimed to need for an abortion in a hospital. While Omar accepted to give this financial contribution, Laura had other intentions and used the money to pay for prenatal consultations instead. Omar's discovery of this situation infuriated him even more, and he broke all contact with Laura. She therefore decided to charge a complaint against him. 'I had warned him to never underestimate me. I haven't spent my time for nothing in the training centre. I learned a lot about women's rights'. She thus declared Omar's neglect to the police – without, however, mentioning a word about the abortion attempts and agreements. The policemen summoned Omar and advised that they try to arrange the affair informally, before resorting to formal procedures or even Omar's imprisonment.

Things were settled in the end; Omar provided for the demanded medication and the layette even before Laura gave birth to her son Stéphane. However, after the return of mother and child to Asung, Omar was quickly out of sight – no visits, no financial contributions. These were also discouraged by Laura's mother, who refused to receive Omar and told him that she was able to take care of her daughter and grandchild by

herself. The first years of Stéphane's life were therefore pervaded by familial contestations about his belonging. Trying to circumvent the constant claims her parents laid on her child, Laura moved back and forth between friends and family members in Asung and its surroundings. She also arranged for a birth certificate through which Omar's paternity over his child was legally established – to the great frustration of her parents.[12] Omar, from his side, not only ignored his son, but also married a Muslim woman. Finally, with the prospect of marriage with Omar thus being blocked – since Laura strongly refused polygamy – and with the conflict with her parents becoming too intense, Laura decided to leave Stéphane behind with her mother and to move to a nearby city, where she had been offered a job in a tailor shop. She started to concentrate on schooling again – this time aiming for a dye training – which she financed with petty trade activities and the money she received from temporary boyfriends. In the relationship with Jean, she conceived again:

> I lived with Jean, a typical big fish as we say here. I did it only for the honour to live with somebody who has a paid job. When he impregnated me, he wanted me to keep the child. But I only thought, 'I still love Stéphane's father. If he will come back to take me into marriage, what will he say if he sees me with another pregnancy?' Because I had made this decision in my life that I would only bear children with one man. And what is more, Jean told me he would take my child, but not me. So why would I keep this pregnancy? Two children, without a marriage? Imagine the suffering. I told the good God, 'Pardon me, I want children, but not with this kind of person. Help me make the pregnancy leave'. So I went to the hospital after three weeks. It was quickly done by a doctor in the evening: with a needle, he removed the water and blood that surround the foetus. He cut the cord that links the foetus to my back; the rest would release automatically. This all happened in the dark; there was no electricity that day. He did everything with a torch. I tell you, that was a moment in which I felt that God was really with me. It didn't hurt and everything went okay. After one week, I started to bleed. It was like a normal menstruation, but it augmented every day. I took a bucket of ten litres. When the blood came, I squatted, and it would pour into the bucket. When I felt how a big ball descended, I warned my cousin, who came to assist me. She was the only one who knew about all this. I had told all other people that I simply suffered from the women's worm. So my cousin came and told me to remove my underpants. I told her I had no force anymore, I felt very tired. As soon as my cousin removed my underwear, I squatted. Plop. At nine o'clock in the evening, it has fallen! In the bucket. At once, with the placenta. The whole package had come out at once. Afterwards, we went to bury the foetus at the garbage dump. That's our tradition. If you would throw it in the toilet where it will rot away, your childbearing leaves. But at the garbage dump, the wind passes; you will continue to give birth.

That Laura was indeed able to conceive again was proven after another year, during my second fieldwork period. I initially found her living in Bélabo together with her son Stéphane – who was now circulating between Laura, mama Denise, and the childless daughter of mama Denise's co-wife – and her new boyfriend Michel. When, after a period of disappearance, I coincidentally met her on the market in the city, she revealed that Michel had publicly hit her and that she had taken him to court. In the meanwhile, she had gone into a new marriage with Philippe, with whom she already conceived. When I asked for her opinion about these sudden changes, she told me that she felt there was

nothing she could do. In fact, this marriage had been arranged by the two mothers. Philippe's mother, as the sister-in-law of Laura's boss, had spotted Laura in the tailor shop where she worked. She had kept on telling Laura that she wanted her as a wife for her son. While Laura's mother had been flattered by this promise, Laura took it as a joke; she did not even know this son who lived at that time in Yaoundé. But one evening, her boss called her into the tailor shop and presented her to Philippe. After a forced conversation, Philippe had convinced Laura to accompany him to his house, as a proof to his mother that they had really met. Hesitantly, Laura had agreed. Once inside his house, they discovered that Philippe's mother was already asleep. Laura, eager to go back to Michel, who would be awaiting her at home, was suddenly confronted with a radical transformation in Philippe's intentions:

> He told me I would not go home. He took a key, closed the door, and put the key in his pocket. I told him I had come to show respect to his mother, not to sleep with him. He said that he is the one who speaks. He wants me to sleep with him. I was afraid! And I knew that I was in my fertile period, so I started to beg him not to touch me. He started to undress. I told him I was in my fertile period and I hadn't brought along anything [i.e. a condom]. He said, 'Is that true? Well, since you're fertile now, that's very good. I will condemn you to me just in one moment. Undress!' We started to fight. I ended up only in my underpants and bra. 'Take off your bra'. I did so. 'Take off your underpants'. I did so. 'Lie down'. I refused. He took his belt and threatened to hit me. He forced me to open my legs. He penetrated me. I told him that he had raped me now. He said, 'Take it as you want. But from today onwards, since I climbed upon you, know that you are my wife. And *voilà* my baby that you carry in your belly'. I told him that I would take some pills [to evacuate] as soon as I would arrive at home. He refused. I said, 'Why wouldn't I abort this? To make a child is firstly a question of agreement. But you do it like this and you want me to keep it? I can't. And anyway, it is not even an abortion, because there is not even a pregnancy yet. You can only abort something that is already a pregnancy. I just want to go and take my products to simply evacuate the sperm'. He locked me up in his house for several days so that I couldn't do that. He told me, 'No, God has written that it is already somebody from the moment of conception. Don't even try!'.

Laura thus found herself 'stuck' with another pregnancy, which led to immediate symptoms in the days that followed. Philippe therefore started to doubt whether the pregnancy was really his – a question that in turn raised fury in Laura. It strengthened her wish to abort this unforeseen, and now also unacknowledged, pregnancy – out of fear of bearing a second child outside of marriage. However, abortion remained out of the question for Philippe and his mother. Since Philippe already had seven children – mostly daughters – but no wife, and he was the only son of his mother, the two did everything to keep the pregnant Laura (and even her son Stéphane) with them. Their constant supervision, as well as their hasty presentation and pregnancy announcement to Laura's family, not only prevented Laura from aborting the now publicly known pregnancy, but also pushed her into marriage with Philippe. This marriage was especially encouraged by Laura's mother, who told her daughter that a second child should be borne within a marital framework, that Laura should abandon all her informal sexual affairs, and that the willingness of Philippe and his mother to engage was rare to find these days. 'This is what

I had hoped for in my heart', mama Denise repeatedly admitted to me. Even Laura's father seemed pleased; while he had blamed his daughter for 'spoiling her school' during her relationship with Omar, he now told me that 'we all know that daughters are there to finally leave into marriage and bear children'.

Laura thus went into marriage. Nevertheless, her pregnancy remained contested and surrounded by the suspicion of her husband and in-laws, who still feared she could have been pregnant before entering the house. This fear culminated when Laura started to experience pregnancy-related illnesses – the treatments of which were supposed to be paid for by Philippe. Anxious about investing financially in what could possibly turn out to be 'false fatherhood', Philippe suggested terminating the pregnancy:[13]

> He proposed to go to a hospital in Yaoundé where they would open my cervix. I told him, 'How can I abort now? I won't. It will stay. Do you know the man whom we call God? God has wanted us to keep it, and we will do so. Haven't you seen those couples that abort a pregnancy because they don't want it yet and wish to search their lives first? And when they finally want [a child], it doesn't come anymore. I don't want that! And imagine if it's a boy, who will lose? You will lose. I know you want a boy. And I also want another child. Do you want me to stick to Stéphane only? What will I do when he will return to his father? No, even if you don't want the pregnancy, I will keep it. I will go and find my mother in the village. We will take care of the child.

To convince Philippe to take this risk, Laura finally uttered a curse: if this child was not Philippe's, it would die right after delivery. If it stayed alive, it would prove Philippe's paternity. In preparation for this crucial moment, Philippe – who had disappeared to Yaoundé quickly after the curse was uttered – and his mother did not arrange for a layette, but wanted to first await the outcome of the birth. Laura's daughter stayed alive; Philippe's paternity was confirmed. It took him months, however, to send money to his wife and daughter for a trip to Yaoundé – which eventually happened during my last fieldwork period. Although excited about finally leaving her severe mother-in-law behind so as to 'go and see the habits' of her husband in the country's capital, which had always attracted her, Laura also remained ambivalent about the possible outcomes. Her opinion about Philippe was heavily influenced by the extramarital affairs, alcohol abuse, and several violent acts he had displayed before his departure:

> I asked him whether he had ever heard that the human rights comprise the right of a man to hit a woman. That doesn't exist! He always claims that the Bible says that the woman is created after the man and that she should therefore undergo his whims. But the Bible only says that the woman 'accompanies' the man. This means she is not subordinate, but she goes with the man out of her own will. I tell you, I will first go and see how I like his behaviour. If it doesn't please me, I will be gone. You know, I am not dependent on him. I am trained as a tailor and I have my own income. I can have a future without a man.

Laura's fears proved justified. In the two months that followed, I received a couple of phone calls from both partners separately. While Philippe complained to me that Laura had apparently come for '*l'aventure*' rather than marriage, since she was 'walking a lot on

the street', Laura confided to me that upon her arrival in Yaoundé, she had found Philippe engaged in a relationship with an old, rich woman. Her refusal of this situation had been met with severe violence by Philippe. She now wanted to flee her marriage. While mama Denise – almost always present during these phone calls since it was the only opportunity for her to talk directly with Laura – first advised her daughter to just 'take her heart off' and 'endure the suffering', she ended up supporting Laura's marriage refusal; after all, Philippe had not only abandoned Laura during her pregnancy and in her current marriage in a big, unknown city, but he had also neglected his obligations towards his parents-in-law. Her initial encouragement of Philippe's bride-price transactions and Laura's childbearing within marriage turned into a refusal of quick engagements and support for Laura's contraceptive plans – thus keeping the option of separation open.

Yet, contraception came too late; during the next phone call Laura told me how Philippe, in order to prevent her departure, had forcefully given her another pregnancy, which she desperately wished to abort. 'I already tried everything: salt, quinine in whiskey, *kangwa* with lemon, *cytotec* from the hospital; nothing works![14] But I really can't keep a second pregnancy for him. I suffer here and I am sure he will kill me one day'. Mama Denise added that a third child would not only diminish her chances of separation with Philippe, but also those of a marriage with another man. Mother and daughter therefore agreed that, if only Laura could succeed in fleeing to the village, I would accompany her to a well-known abortion specialist and get it done.

And so we did, on that chilly morning in August 2009. Lying on her bed in her dark bedroom during the days that follow, Laura thinks back on all these experiences with mixed feelings. Her joy of having successfully fled the disappointing marriage with Philippe becomes mixed with insecurity about her marital future; her joy of having parents who, after all, seem to support her in her current decisions becomes mixed with resentment about past decisions negatively influenced by them; her joy of having successfully undergone her first abortion intervention becomes mixed with insecurity about the final 'fall of the foetus'; and her joy of having her two children at her side becomes mixed with insecurity about the moral implications of having aborted others. She contemplates:

> After my abortions, I often fast. During a whole day, I do not even swallow my own saliva. I don't drink and I don't eat. Oh, how the day is long then! I try to sleep and let the day pass. And I pray a lot. Like this, I demand God's pardon, because I aborted. Even now. I ask him to help me, to not let me fall, to understand my situation. I don't refuse to bear children, but it is my current situation that does not allow for childbearing now. I suffer. So I pray at whatever moment of the day. It takes me like that. It is like a small voice in my head, which tells me, 'Laura, pray!' Even in the middle of the night, when I wake up, there is something that tells me I should pray. I can't neglect. I tell Him what I have to say. Sometimes, when I'm really touched, I start to cry. My tears flow. And afterwards, it stops and I go to bed and sleep. I tell myself that it is really God who calls me at such moments. Since he has many children, he cannot listen to everybody at the same time. Therefore, He sends me the message that He is free to listen to me. So I need to respect it when he calls upon me.

In the ensuing discussion on divine judgment and life destinations, I ask Laura how she envisages her future. Surprisingly, she invokes her past, short-lived relationships to come to the conclusion that she would like to end up with the one she loved most: Omar. While her mother still claims that a marriage between the two would be impossible – invoking Omar's 'lack of love' for Laura, the birth of a daughter with another man, and her own love for Stéphane, whom she would refuse to give back to his father – Laura's father had recently displayed a more positive attitude towards Omar. It creates new hope in Laura, who speculates:

> Here, we often say, 'You never pluck a mango to leave it behind on the spot' [*wādipong adókh wolīk a tyin*]. If you pluck a mango, it is to eat it immediately. If you store it or let it fall, you will not find it back. Somebody else who will pass will pick it up and eat it in your place. It is like that with relationships as well. If I found other men, that is because Omar had plucked the mango, but let it fall. Others have come and have picked it up. But I know that if destiny has written that I will be together with Stéphane's father, I will always end up with him. There have been some *marabouts* who told me that he still wants to take me as a wife. And he himself says that he will be the one who will finally marry me. When he will come and claim Stéphane, he will take me in his house as well. He predicted that all the other relations that I have will never last. And you know, Omar is the one who deflowered me. So everything he will tell me will be realized, since he is now like my father and mother who brought me into this world. It is like a curse. What can I do about it? The only thing I know is that I cannot make the error of becoming pregnant again. Because I took this decision in my life that I don't want to give all my children with different fathers. I would even want to take *Norplant* or injections and stay calm.[15] I won't move. But at the same time, I don't feel like staying too long here in the village with my parents. I feel like going to the younger brother of my mother in Douala. I would like to start a small trade in jewellery or in wrappers there, for instance. Even in Ngaoundéré. There, I might meet Stéphane's father [who originates from this city]. Who knows? It is the destiny of God.

It is in this indeterminate situation that I leave Laura behind. A few days later, after my arrival in the Netherlands, she tells me on the phone that, due to some injections given by the doctor in the village's dispensary, the foetus has finally fallen. She will soon start with contraceptive pills and take time to see what the future will bring to her. With Stéphane reaching the age for return to his father, she might follow her son and end up in a marriage with Omar. Now that this foetus has fallen, the fallen mango might be picked up again.

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The stories of mama Rosie, who remained childless in the village of Asung, and Laura, who interrupted her pregnancies while living in the city, could be considered each other's opposites in at least two ways: in terms of the narrated reproductive experiences and in terms of the geographical areas in which they are situated. Many international and academic debates have taken these differences as a starting point for theorizing women's agency and suffering. Yet, such theorizations do not reflect the ways in which

Gbigbil women manage, talk about, and give direction to their lives in general, and their reproductive experiences in particular. In looking *beyond* those respective differences, I will show how both stories reveal a shared narrative ground upon which women draw to make sense of their (reproductive) suffering and decision-making, and which helps them navigating their vital conjunctures within complex social situations.

Before delving into those local idioms, however, the next section will first outline some dominant understandings of agency and suffering in lay and scientific thinking. I will show how different fertility events and geographical locations are often associated with one or the other, which, in turn, creates a conceptual divide between female victims and agents. This dichotomous thinking is equally present in writings about, and official discourses in, Cameroon – despite the fact that Cameroonian women themselves, at least those in Asung, seem to hold completely different ideas about their '*souffrance*' and their abilities to exert '*politiques*' in order to attain their goals. The second part of this chapter will expose these Gbigbil ideas, and illuminate how they direct the navigation of different reproductive conjunctures, by women with rural and urban aspirations alike.

On patriarchal powers and modernized *mamas*: agency and suffering reinterpreted

Infertility and abortion stories like the ones presented above have, although both increasingly researched (see Introduction), often been approached as dissimilar events. The reproductive *ambitions* of women who involuntarily remain childless and of those who voluntarily abort their pregnancies are perceived to be opposite: *wanting* versus *not wanting* children. Psychologists have argued that these different underlying desires result in clearly dissimilar physical and emotional experiences in both cases.[16] Some feminists propose going one step further. For them, both these different ambitions and their respective effects should be considered in the light of a supposedly dominant patriarchal order[17] that prescribes women to produce offspring, imbues them with a 'natural' desire for children, and grants them social status only if they succeed in realizing this desire through live births and successful motherhood.[18] Women who remain childless would want to adhere to, but be unable to attain, these norms;[19] to the contrary, those who interrupt their pregnancies are perceived as explicitly contesting them (J. M. Fischer, 2003; Hanigsberg, 1995; Hewson, 2001; Kim, 1999; Meyers, 2001; Petchesky, 1980; Thomson, 1971). Infertility has thus been interpreted as the ultimate form of (physical, emotional, and social) suffering within patriarchal structures, while abortion is often celebrated as the ultimate form of agency.[20] Many anthropologists, even if they do not explicitly cling to a feminist agenda, have implicitly reiterated this association.[21] Such a conceptual framework divides women into victims and agents respectively.

I have already argued in the previous chapters that reproductive ambitions and the desirability of a pregnancy are in themselves often changeable and contradicting; to

attribute fixed desires to either infertile or aborting women is therefore always problematic. To conceive the one in terms of mere suffering and the other in terms of agency further reduces the complexity that characterizes vital conjunctures at both ends of the reproductive continuum. This is of course not to say that women – in this Eastern Cameroonian society and elsewhere – are not embedded in patriarchal systems or gendered power relations; yet, the mere existence of such frameworks and women's divergent reproductive experiences within these frames cannot form the sole basis on which to predict women's ambitions and levels of agency. Matters seem to be much more nuanced in the individual stories of my informants. Not only their ambitions, but also their notions and experiences of suffering and agency, are in practice often blurred.

Some feminists have rightfully started to question this strict dichotomy between victimization and agency (Connell, 1997; Mahoney, 1994; Pollack, 2000; Schneider, 1993), as well as the decontextualized, essentialist notion of a widely 'shared female experience' (Petchesky, 1980) defined by some sort of universal patriarchy (Inhorn, 1996; Kandiyoti, 1988; Lock & Kaufert, 1997, p. 9). These feminists have, like some anthropologists, called for 'a more textured and contextual analysis of the interrelationship between women's oppression and acts of resistance in a wider range of women's circumstances' (Schneider, 1993, p. 397).[22] In this chapter, I do not only aim to answer this call and to overcome the 'incomplete and static view of women as *either* victims *or* agents' (ibid., p. 387, emphasis in original); but by taking my informants' practical realities and discursive practices as a starting point, I will also scrutinize the assumption that this dichotomy should be understood within, and is actually the result of, some fixed patriarchal order. In line with Lock and Kaufert (1997, p. 3), I criticize the 'one culture/one gender system' in terms of which women's positions have too often been interpreted.[23]

There is yet another way in which dominant thinking divides women into victims and agents. Influenced by modernization theories and development thinking, international and academic debates on womanhood in developing countries have come to postulate an important difference between rural and urban women – or women with rural and urban aspirations, for that matter. Urban residence, education, and exposure to modernity are considered key contributors to both the development and the empowerment of non-Western women.[24] As such, those residing in the village are generally depicted as poor and powerless sufferers, whereas their urban counterparts have become icons of development, knowledge, and autonomy. Not surprisingly, such images are often quickly married with the afore-mentioned distinction between women as *reproductive* victims and agents. Thus, women in villages suffer under patriarchal and pronatalist demands, whereas those with more money, knowledge, and power in the city are able to resist those 'traditional' schemes and resort to modern methods of contraception or abortion.

Both lines of thought have been applied to the Cameroonian context as well. Over time, a whole body of knowledge and practice (created by scientists, clergy,

governmental and non-governmental organizations) has contributed to an image of Cameroonian women as (reproductive) sufferers under patriarchy, who could (and should) be empowered through their acquaintance with modern, urban frames of reference. The earliest anthropological accounts of the Eastern region of the country, for instance, never failed to emphasize the existence of male dominance and the resultant exclusion of women in the local communities they studied. Most ethnographic descriptions relate how male positions as household heads, warriors, or exchangers of wives granted men material power and symbolic authority. Invoking local sayings like 'a woman has no voice' or 'a chicken does not sing in front of a cock', they indicated that women were not only considered subordinate to the orders of men, but also – deprived of their speech – excluded from socially acknowledged powerful positions in these communities (Balla, 1991; de Thé, 1970; Laburthe-Tolra, 1981, pp. 821-823; Vincent, 1976). Laburthe-Tolra speaks of an extreme 'objectivation' of women, who are:

> … at most reduced to the state of economic instrument deprived of subjective expression. In all circumstances, she first has to shut up, to keep silent. Won, sold, lost at a game, hired, lent, deprived of every capacity in the juridical sense of the term, not able to possess anything, the woman is held at the margins of all domains, without any other bond to humanity than the connection more or less held with her lineage of origin and the advantages associated with maternity (Laburthe-Tolra, 1981, p. 890, my translation).

It is often noted how the rights *of* women were virtually absent in these wife-exchanging communities where men established rights *over* women – and their fertility – through bride-price transfers (see, for instance, de Thé, 1970, p. 32). In such a context, as also indicated by Laburthe-Tolra's last words above, women would only be able to assume subjectivity as 'producers of food and reproducers of people' – contributing to men's status with their labour force and childbearing capacities (de Thé, 1970; Laburthe-Tolra, 1981). These sources have consistently portrayed motherhood as highly valued – by patrilinies and, by implication, also by women themselves, who thereby acquired a place and status within this patriarchal order. Not surprisingly, accounts of induced abortions are strikingly absent in these early ethnographies, and infertility – a widespread phenomenon in the region until the late twentieth century (Cates et al., 1985; David & Voas, 1981; Ericksen & Brunette, 1996; Frank, 1983; Larsen, 1995; Nasah, 1978; Retel-Laurentin, 1974; Romaniuk, 1961, 1968) – was merely interpreted in terms of social vulnerability and stigmatization.[25] Depictions like these rendered women speechless in a system that grants them 'no voice', and portrayed them as victims who suffer the burden of the patriarchal yoke.

Several colonial interventions and post-colonial institutions have taken up, and contributed to, this image with their discourses of empowerment. To begin with, Christianity aimed to play a pivotal role in this process. Ever since the first Christian missionaries arrived in Cameroon in 1890 and reached the East Province in the 1930s, they have been preoccupied not only with conversion to Catholicism but also with the

eradication of local habits that they deemed incompatible with the Christian dogma. Structural social issues such as gender relations and marital arrangements were combated by missionaries who held other views on social life and relationships. A 1972 diary excerpt of a Dutch Catholic Father who worked in the diocese of Doumé (which, at that time, comprised Asung) notes the ubiquity of four local habits which proved irreconcilable with Christian doctrine: premarital sexual relationships and cohabitation; divorce; polygamy; and levirate (widow inheritance).[26] Apart from the incompatibility of these issues with Christian conceptions of marriage as a life-long sacred union and exclusive framework for monogamous sexual relationships, they raised moral questions about women's roles and positions in society. In order to both regulate women's sexual and marital lives, and teach them about their positions vis-à-vis men, the Catholic missionaries created an institution called *sixa*, which became widespread in the Southern part of Cameroon from the 1930s onwards.[27] Next to its goal of directly linking conversion with monogamous marriage, it aimed to 'liberate' women from local male-dominated and 'dehumanizing' institutions. Over time, this discourse of Christian emancipation was reiterated by Western anthropologists and their informants alike. On the basis of conversations with Beti women, for instance, Vincent claims that:

> the veritable liberation brought by Christianity to women was the new possibility to make themselves heard: Christianity gave voice to women (…). It is Christianity that gave them the dignity of a human person. Their first way to express themselves was refusal (Vincent, 2001, p. 56, my translation).

Recent developments and institutions have further fed the image of women being in need of 'liberation' and 'empowerment'. Over the last three decades, Cameroon has witnessed the creation of a Ministry of Women's Empowerment and Family (MINPROFF);[28] certain laws concerning women's rights (with regard to physical integrity, marriage, divorce, or inheritance); educational programs; women's associations and NGOs; and the yearly International Women's Day on the 8th of March. These institutions proclaim a specific focus on women as individuals, who should be independent and have the same rights and possibilities as their male counterparts. The discourse on women's suffering is, again, one that takes male oppression and female speechlessness as a starting point, and that posits the adoption of urban, modern frameworks as the key strategy to attain autonomy – in reproductive as well as other domains of life.

Yet, many studies have by now revealed that this image of female speechlessness is often far removed from daily life realities in Cameroon.[29] They have indicated that in practice, and especially in the domain of reproduction, a clash between patriarchal norms and practices is clearly recognizable – both in urban and in rural settings. Furthermore, they have called for a more detailed focus on the varieties and power differentials *between* women – of different generations or families, for instance – within the same setting (Abega, 2007; S. G. Ardener, 1973; Barbier, 1985; Copet-Rougier, 1985; Geschiere, 1985; Nkwi, 1985; Notermans, 1999). The life stories of mama Rosie and Laura, as well as

those of Yvette and Sophie in the previous chapters, similarly show that much more is at stake than the mere rural subordination to, or the urban contestation of, a supposedly dominant patriarchal framework that renders women speechless. In comparing both narratives, portrayals of rural infertility as mere suffering and urban abortion as pure agency become questionable. What, then, can be said about Gbigbil women's reproductive suffering and agency? The following sections will address this question by looking into women's *own* perceptions of suffering, fate, and decision-making potential – and the ways in which these play a role in their reproductive navigations.

The paradox of powerless portrayals: situating idioms of suffering and fate

Utterances of speechlessness and powerlessness are commonplace in Asung.[30] Whatever the topic of conversation, my female informants would often repeat that they have 'no mouth to speak with' ('*on n'a pas la bouche à parler*'; '*munka atəka num a jo*') and that they are obliged ('*on est obligé*') to do what others demand from them; what else can they do ('*on peut faire comment*')? Any outsider might be tempted to comprehend these complaints in terms of male authority and female submissiveness – consistent with earlier ethnographic accounts and modern discourses of empowerment. Women's idioms of powerlessness would then be interpreted as representing their gendered oppression and lack of agency.

A more thorough investigation of practical realities in the village, however, reveals a discrepancy between women's utterances of powerlessness and their relative independence in both the productive and reproductive domains.[31] For, while land is the property of Gbigbil men (and their lineages) in Asung, all married women receive their own plot and work on it individually. Although they may cooperate with either their husbands or other women in times of economic shortage or field abundance, in general women enjoy practical and economic independence in their roles as producer (see also Delpech, 1985; Geschiere, 1985; Goheen, 1993, 1996; Vincent, 1976). Similar liberties appear in the domain of fertility. The previous chapters have already indicated how women *do* have room to manipulate men, exert power, or engage in 'secret strategies' (Koster, 2003) – despite the proclaimed control of men over their wives' fertility. Further, Gbigbil women are not afraid to charge informal or formal complaints against their husbands or to publicly express themselves in village palavers, police stations, or courthouses. Thus, more must be at stake when women portray themselves as powerless and without a voice. How is this paradox to be explained? What do Gbigbil women imply and imagine when they talk about their powerlessness?

Depictions of powerlessness are expressed in multiple ways. At least four discursive themes can be discerned in women's common complaints: suffering, fate, resignation to religious dogma, and submission to patriarchy. First of all, women deploy a widespread, pervasive idiom of suffering (*diuk*). In commenting on all sorts of negatively

experienced life contingencies, but especially their encounters with men in sexual and marital relationships, women never refrain from stressing the '*souffrance*' they face. Rather than corresponding to a patriarchal image of women as oppressed inferiors, however, such complaints of speechless suffering paradoxically create a common denominator of womanhood that grants my informants a feeling of female solidarity and even superiority. Indeed, it is exactly the capacity to suffer that marks them as good women and wives. Perseverance and endurance – both physically (through working in the fields) and emotionally (through 'taking the heart off' [*enlever le coeur*], as mama Denise advised Laura on the phone) – are highly valued traits inculcated in women from a young age onwards (see also Chapter 3). The ability to suffer in marriage is a focal point in girls' education, and presented as *strength* rather than *weakness* – something to be proud of as a woman.[32] It proves not only one's capacity to endure, but also the efforts one is willing to make to attain a valued goal.[33]

Yet, this is only part of the story. If women's reinterpretation of suffering as a form of shared, *hidden* strength might still create the impression of their passive compliance with the dominant framework, in practice it becomes also *explicit* and *instrumental* in their daily life navigations. The *religious* meanings and merits with which Gbigbil women often imbue their complaints about suffering in particular create this possibility for instrumentality. Comparing their ordeals to those undergone by Jesus, women often talk about their '*souffrance*' in terms of a cross they have to carry. During a focus group discussion on agency and suffering, Peggy, who worked as a nursery teacher at the Catholic missionary station, noted:

> People often say that you carry the cross that God has given to you. And you should carry it to the bitter end. You should always endure your suffering. You should dominate your suffering. Suffering is a school of wisdom, it is part of life. You should abandon discouragement. You should be strong. You should be perseverant in order to succeed, in order to dominate this suffering.

Not only do notions like these make unexpected daily life adversities more meaningful and acceptable, but they also endow women with 'feelings of moral superiority' (Notermans, 1999, p. 174). The idea that women carry their personal 'cross' during life is often complemented with a notion of divine judgment upon death. On Judgment Day, God – perceived as the sender of ordeals and the omnipresent 'observer' of daily life events – will reward those who showed persistence in their suffering. Victims during life will turn into victors after death. Religious rhetoric thus adds a moral element to idioms of distress; suffering is not only an expression of shared female strength but also of individual 'moral superiority' that will be rewarded in the future.

This moral projection of religious salvation is tactically deployed in social relationships in women's daily lives. For, while it promises sufferers to be rewarded, it also posits that those who *inflict* suffering upon others will be punished relentlessly. The discourse of divine judgment is thus often used to comment upon the bad behaviour of

others; claims of one's own moral *superiority* imply others' moral *inferiority*, just as claims of one's own victory imply others' defeat. These supernatural associations of suffering are often evoked in a context where women's reproductive lives are characterized by power struggles with men or other women – either in polygynous households (see also Chapter 3), or in informal flexible relationships (see also Chapter 4). Mama Rosie's story illustrates how such a discourse becomes shaped within a competitive polygynous setting. Her invocation of marital and reproductive suffering not only confirms her own strength and worth as a (religious) woman, but also comments upon the moral weakness of her (evil) co-wife, who, by inflicting this suffering upon mama Rosie, is doomed to be severely punished afterwards. By strengthening her point through witchcraft accusations and mystical accounts of hanging underwear, mama Rosie's portrayal of suffering becomes a translation of daily life struggles into supernatural competitions – from which she will eventually emerge as a good winner, and her co-wife as a bad loser (for similar discursive dynamics among the neighboring Mkako, see Notermans, 1999).

Second, instrumental dynamics are at play in women's idioms of *fate* – which, in their view, is intrinsically linked to God's will. As noted in Chapters 2 and 3, women's marital and reproductive life stories are pervaded by an all-encompassing idea of predestination and divine determination. Paradoxically, however, this idea is tactically deployed – uttered at moments when it can give appropriate meaning and direction to the vital conjuncture at hand. The narratives of mama Rosie and Laura, for instance, show how a certain idea of marital predestination co-exists with explicit management of conjugal situations and futures. Mama Rosie considered Etienne as 'the man whom God had given to me', while at the same time she maintained relationships with different men, gave her pregnancy to another candidate, and explicitly refused marriage with that same Etienne some time afterwards. Likewise, Laura justified certain partner choices as 'written by God', while she also acknowledged her active sexual and marital search through the metaphor of the fallen mango – an expression which, just like the Gbigbil sayings 'you should never throw bones to a dog' ('*bādibu biya iveey*') or 'a woman is like a *menyenge* leaf' ('*munka ane da akei menyenge*'), touches upon the quick (re)entrance of single or divorced women into a new union. Indeed, the motivation invoked by both women to 'go and see' upon entering marriage underlines their imagined possibility of leaving the union if it is not in accordance with their wishes – a decision that may again be justified through notions of predestination or God's approval afterwards.

Intentional interventions in the domain of *fertility* are similarly justified through ideas of predestination. Mama Rosie repeated that she had put her reproductive outcomes in the 'hands of God', while at the same time she actively searched for different treatments, uttered witchcraft accusations against her co-wife, claimed the children of her siblings, and assured her childless future through the (secret) demand of a marriage certificate. Laura started to interpret her pregnancies as being sent by God – predetermining the life of her first child, and making her keep the second one – after her

abortion attempts had failed and prospects of bearing a child had become more attractive. Her expression 'God has wanted us to keep it [her third pregnancy], and we will do so' shows how the deployment of passive notions of fate is as tactical an option as her decisions to take contraceptives, or to alleviate her current or imagined future suffering through abortions.

Third, more specific than notions of divine predestination are the particular Biblical passages that are resorted to in order to explain circumstances or justify decisions. Again, the image of resignation and powerlessness that such expressions portray covers the pragmatism with which they are selected and deployed. Insightful is the discussion between Philippe and Laura concerning the passage in Genesis 2:18-24 – often invoked by my informants – depicting God's creation of a woman out of the rib of a man in order to give him accompaniment; while Philippe saw it as justification for women's subordination, Laura inverted its sense to a situation of equality where a woman 'goes with the man out of her own will'. Similar tactical interpretations surround the biblical passages that are invoked as justifications for gendered divisions of tasks and responsibilities. The commandment in Genesis 1:28 to 'be fruitful and multiply, and fill the earth and subdue it' – repeatedly stressed by missionaries ever since they arrived in the 'under-populated' East Province in the 1930s[34] – is often cited by villagers to support local patrilineal ideals and to remind women of their reproductive duties. Yet, mama Rosie mentioned it to strengthen her witchcraft accusations and Laura contested it by her abortion attempts and her conviction of God's situational understanding. Both women claim to resign themselves to the 'word of God' as ultimate truth directing their lives and decisions, while they constantly interpret it differently in contingent situations.

Fourth, just like Biblical passages on gendered relations, local patriarchal notions are situationally used as justifications or contestations of certain circumstances. In line with what I described in the previous chapter, I argue that patriarchal notions are certainly existent but seem to form a normative framework – an official 'kinship idiom' (see Geschiere, 1982, and Chapter 1) – that is sometimes confirmed and sometimes contested by practical realities. Both Laura and mama Rosie refer to the norm according to which they should marry with one man, endure his whims, and bear children for him – while always recognizing the discrepancy with their actual situations. As such, Laura's repeated claim that she wants to 'only bear children with one man' is more an ideal tactically mentioned in the face of discrepant realities than a passive acceptance of an imposed order. Likewise, it is in a situation in which Laura is unexpectedly faced with Philippe's proposal for an abortion – a proposal that in itself violates patriarchal ideals – that she suddenly refers to the supposedly male desire for male offspring to make Philippe accept the child that she herself actually wants. Patriarchal and pronatalist frameworks, rather than to be taken as a fixed starting point informing women's powerlessness and suffering, should thus be considered idioms that are as flexibly deployed as idioms of powerlessness and suffering themselves.

Notions of suffering, fate, religious resignation, and patriarchal submission thus contribute to a general portrayal of powerlessness, but veil as much as they publicly reveal. They are often more *instrumental* to women's navigation of vital conjunctures than they seem to be *obstructive*. They give reproductive conjunctures not only *meaning*, but certainly also *direction* since they can be turned into justifications for decisions made and (overt or covert) projects pursued – irrespective of what these actually are. This leads to a paradoxical situation: while women portray themselves as powerless, such portrayals are actually empowering, and even a manifestation of women's power itself.

This paradox works in two ways. First, portrayals of powerlessness create room for *tactics*. In the sense given to the word by Michel de Certeau (1984), these tactics allow women, who might not have the power to define and impose dominant frames of reference, to inventively use and reinterpret these very frames in order to pursue their own goals – without upsetting the dominant order.[35] As such, de Certeau defines tactics as 'the ingenious ways in which the weak make use of the strong' (ibid., p. xvii). As an 'art of the weak' (ibid., p. 37), tactical behaviour requires constant adaptation and improvisation; people 'must constantly manipulate events in order to turn them into "opportunities"' (ibid., p. xix). Gbigbil women's flexible use of dominant discourses about suffering, fate, religious dogma, and patriarchy can be considered tactical because it is enacted at moments and in situations where clinging to the dominant frame (in its original or reinterpreted form) allows women to pursue their projects and to justify their actions or their explorations of certain horizons. This is not necessarily to say that women *are* weak, however, but that they are best able to deploy these tactics when they *portray* themselves as weak. The portrayal of weakness is thus a tactic in itself.

Second, these discourses, and especially the complaints about suffering, allow for a critical self-awareness and a *shared* self-perception in terms of 'superior womanhood'. They can therefore function as *hidden transcripts*, a term used by James Scott (1990) to designate 'discourse that takes place 'offstage', beyond direct observation by powerholders' and that 'consists of those offstage speeches, gestures, and practices that confirm, contradict, or inflect what appears in the public transcript' (ibid., p. 4). In this sense, the term draws attention to the room for, and capacity of, subordinates to define their own subversive worldviews that might *challenge* the dominant order, even if they seem to passively comply with the public transcript of domination. Often, this hidden transcript is the complete opposite of what is proclaimed in the public transcript. In the Gbigbil case, the hidden transcript seems not so much to consist of completely different *notions* than those that appear in the public transcript of patriarchal domination and female submission; rather, it attaches completely different *meanings* (allegedly hidden and shared by women only) to this very public transcript – through which statements of powerlessness paradoxically become empowering.

There is yet another, less hidden, way in which portrayals of powerlessness can become a source of challenge and power. This happens when the different themes of

powerlessness (but especially the ones invoking suffering and patriarchal submission) become vehicles to *overtly* denounce undesired situations through appeals to official authorities (such as the police or court of justice). As shown in Laura's story, idioms of suffering and submission are effective elements of such public charges because the authorities to which women resort employ frameworks of female victimhood that are responsive to such complaints. Based on (inter)national paradigms of women's subordination and the fight for empowerment and equal rights, such frameworks imbue suffering with completely different connotations than the women themselves (secretly) do. Yet, again, in making their complaints compatible with the dominant discursive frame that pervades these public spaces (that is, in exploiting the Western public script that is so critical of female suffering) women search to pursue their private projects and even openly challenge the *status quo*.

To draw attention to these tactics and hidden, or less hidden, transcripts is to counter the ideas about women's lack of voice, as present in certain strands of literature and development thinking. In the process of enacting the above outlined paradox, women not only *have* a voice, but also make it *heard*, and through this, are sometimes even in actual power. Idioms of powerlessness thus veil different kinds of agency that are often considered the exact antithesis of powerlessness: having a voice (i.e. using and reinterpreting dominant frames), making one's voice heard (i.e. actually attaining one's goals through such use and interpretation), and having actual power (i.e. being able to challenge the dominant framework and its power holders, through sharing hidden transcripts or charging public complaints). Different situations allow for different forms of agency; sometimes women can only operate through exploiting the 'cracks' in the dominant framework, while at other moments they are able to challenge it altogether. Women may not always have actual power, then, but they rarely lack a voice.

Most of my female informants are aware of these different kinds of agency that can be attained through tactically clinging to particular passive discourses. It is what they call their '*politique*' and they are proud of it. While men would tell me that 'women are like children' because they can be easily satisfied, women would readily reciprocate this stance towards their male counterparts, saying that they could be easily misled under the veil of suffering or other expressions of powerlessness. Successful exertion of these discursive 'politics' requires skills of anticipation and adaptation, as one should always take into account the social contingencies during one's life course. Towards the end of the focus group discussion on agency and suffering, Lianne metaphorically concluded:

> We shouldn't have constrained visions, but look a bit ahead. A woman should walk like a cat. Why? Because before posing her feet, a cat knows whether it's good or not good to walk where she walks. If there's a mouse, she knows how to walk. If there's no mouse, she knows how to walk. So a woman should be like a cat. She should know where to walk, what to do, with whom to walk, and what to say, in order to attract people who will form her physically and spiritually. Some women spend a hundred years somewhere without being able to

> change. But there are others who know how to adapt their lives and language right upon their arrival somewhere. It's these women who will succeed.

For Gbigbil women, whose lives are characterized by constant geographical, marital, and social mobility – moving from their own families into those of their husbands, from rural to urban areas and back, and changing their social positions along the way – adaptation and anticipation might long have been a key to their 'success'. These characteristics are even more warranted in the current environment of increasing political and economic instability and social precariousness, as described in Chapter 1. Given that 'contingency contributes significantly to the creation of experiential uncertainty' (Johnson-Hanks, 2005, p. 370), and that women nowadays live within a 'routinized state of uncertainty' (ibid., p. 376), it is not surprising that they formulate their (different kinds of) agency as *judicious opportunism* at most; their 'politics' are immediate reactions to the contingent, sometimes constraining, circumstances they encounter during vital conjunctures – rather than rational calculations based on prior intentions, educational background, or fixed hegemonic frameworks.

To focus on these possibilities of judicious opportunism (in the form of tactical behaviour, hidden transcripts, or more overt forms of pursuing one's projects) is thus not to say that women are not at all constrained in their navigations, or not subject to power hierarchies; rather, they use their idioms flexibly according to the particular power relations at hand. Nor is it to say that the display of these idioms of distress cannot by itself be constrained or precarious; especially in periods of contestation, they can easily be inverted and work out in negative ways. In uncertain and ambiguous reproductive conjunctures, for instance, portrayals of powerlessness and power are no less uncertain and ambiguous. The following sections will explore these uncertainties and ambiguities; they will trace how both suffering and agency are at play in specific narratives on infertility and abortion.

Infertility: accusations and alternative forms of agency

Infertility violates patriarchal norms to bear live children for the family of the husband, and is on that basis often described by existing literature and my informants as surrounded by suspicion, accusations, and public insults. The Gbigbil word for an infertile person (*kun*) has been translated as 'rubbish', 'rocky', and 'prisoner' in related Beti languages (Guyer, 1984; Tsala Tsala, 1996); an infertile woman might also be called 'a woman of nothing' ('*munka asumba*'), 'a sterile thing like you' ('*kun yom da we aná*'), or faced with questions like 'when will you give birth, huh?' ('*wibial dī e?*'), 'have you only come to fill the toilet with excrement?', or 'who will bury you when you die?' ('*abok a wiwa, zá nye opum?*'). In a context where female worth is ideally considered in terms of successful motherhood, the burden of childlessness is said to fall largely on women; though many informants would admit that male infertility exists, they would also state

that it remains hidden under public accusations towards women. Similar attitudes have been found elsewhere within and outside of Cameroon (Bleek, 1976; Copet-Rougier, 1985; Feldman-Savelsberg, 1999; Inhorn, 1994, 1996; Kielmann, 1998; Leonard, 2002; Nahar, 2007; Njikam Savage, 1992; Sundby, Mboge, & Sonko, 1998); they tend to confirm the overall image of infertile women as passive sufferers of a patriarchal hegemony (see also Gerrits, 2002).

Within this setting, infertile women are often preoccupied with the portrayal of an image of innocence. Hereto, they tactically deploy an aetiological repertoire that presents different levels of culpability. Just as in cases of pregnancy interruption (see Chapter 4), the aetiological explanations for infertility are multiple and pervaded by ambiguity – always acknowledging the possibility that the childlessness might be *intentionally* brought about. Although some informants would invoke the 'wish' or 'creation' of God to account for childlessness, others contest this contention on the basis of God's commandment in Genesis 1:28 to 'be fruitful and multiply'. They rather focus on the circumstances that may have rendered certain women childless. These can be externally imposed, beyond the will or intention of a woman; both first-hand and second-hand accounts of cruel witches destroying the fertility of their co-wives or competitors – like in mama Rosie's story – abound in the village.[36] I have already argued how mama Rosie's idiom of suffering under the attacks of her evil co-wife should be considered tactical in different respects – one of them being the display of the self as innocent. For, very often, sterility is perceived to be ultimately caused by childless women themselves: they must have consciously 'blocked' their childbearing; their witchcraft must have 'eaten' all the foetuses in the uterus; their disobedience must have provoked a curse by family members; or their sins – like previous abortion attempts – must have led to a punishment by God. For outsiders, the question of intentionality, as well as the distinction between suffering and agency, becomes blurred and contested in cases of infertility.

Apart from creating an image of innocence, idioms of suffering also form justifications to actively search for (indigenous and biomedical) help after too long a period of childlessness. A portrayal of innocent suffering might rouse compassion and induce (financial) help from social others and thus increase the chances of obtaining infertility treatment. As mama Rosie's story showed, multiple healing sources can be consulted at the same time. Popular in the region are methods which are believed to 'wash the stomach' – both indigenous medicines and dilation and curettage (D&C), a potentially damaging biomedical intervention that is no longer considered as an infertility procedure by the World Health Organization (Hunt, 2005, p. 431). The procedures that *are* considered appropriate within the biomedical framework are much less used by Gbigbil women. Although infertility is now recognized as a component of reproductive health, and the fight against it is an explicit objective of the 1992 'National Population Policy' in Cameroon, biomedical infertility care faces problems and limitations on the ground. Detection in Asung is, according to the local doctor, based on simple tests and

speculations – after which patients will have to be referred to provincial hospitals in Bertoua or Ngaoundéré to have an ultrasound done. Few are the women, however, who, like mama Rosie, actually follow such a biomedical path.[37]

Due to a predominant aetiology that recognizes disruptions in social harmony as important contributors to fertility problems, and due to a resulting idiom of suffering which is essentially *social*, biomedical examinations are often replaced or complemented with healing and detection methods that take these social causations of infertility into account. Healers and *marabouts*, who are believed to constructively draw upon occult powers (see also de Rosny, 1974; de Thé, 1970, p. 48; Johnson, Thompson, & Perry, 1990; Mallart Guimera, 1981; Van Beek, 1994), are especially deemed effective if supernatural forces are suspected to cause the infertility. Women with fertility problems, like mama Rosie, often resort to different healers, who provide them with different explanations for their suffering – and deploy these utterances tactically, within the social relations and power differentials at hand.

However, violation of the normative framework and the ensuing inventive search for, and use of, aetiological explanations is just one side of the infertility story. I have already argued above that the patriarchal, pronatalist framework in itself can be tactically deployed, utterly contested, or ignored in specific vital conjunctures and social situations; this is also done by infertile women. They may downplay their lack of biological motherhood in favour of other identifications or sources of status. Mama Rosie, for instance, claimed that respectful womanhood derives much less from one's childbearing capacities than from 'the work that you do in front of the people and your husband'. And indeed, in practice, barren women often occupy important positions – within their marriage and within the village (see also de Thé, 1970; Laburthe-Tolra, 1981). Mama Rosie's use of modern knowledge and official positions as well as traditional forms of authority illustrates this clearly. Gbigbil men seem to confirm that infertile women are able to hold certain positions *despite* or exactly *because of* their childlessness; mama Rosie's brother-in-law appointed his dynamic sister-in-law as the governor of his *quartier* and papa Gerie told me more than once that mama Rosie was not only the wife he loved most, but also his 'wife of *ambiance*' – able to host his guests, to animate communal gatherings, and to 'talk in his place when he is absent' (de Thé, 1970, p. 386).[38] Even if some people – like Laura and her kin – might contest this explicit challenge to the normative order, such contestations can easily be countered with portrayals of suffering and infertile victimhood that logically follow from the same set of norms.

Lastly, it should be noted that images of infertility-related suffering as depicted in the literature are often based on notions of exclusive biological motherhood. They overlook the possibilities for social motherhood through fosterage – a widespread institution in Cameroon and other West African countries (Alber, 2003; Carsten, 2004; Einarsdóttir, 2006; Eloundou-Enyegue & Stokes, 2009; Goody, 1984; Notermans, 2003, 2008; Verhoef, 2005). The stories of mama Rosie and Laura illustrate that these

possibilities are omnipresent in Asung, especially when women remain biologically childless: they show the vigour with which mama Rosie claimed the children of her brothers, gave her own name to newborn babies, and portrayed herself as a 'mother of everybody', as well as the ease with which Stéphane circulated between Laura and the childless daughter of Laura's *maratre.* Rather than viewing these social forms of motherhood as 'precarious solutions in crisis situations, with somewhat 'deviant' connotations' – a view which is noted by Alber (2003, p. 488) to be predominant in fosterage literature – they should be considered the expression of a widespread notion of belonging in which 'the child of your sister is your child', as my informants often told me. Claims on these children may be tactically strengthened by an idiom of suffering; expressions like 'when you suffer all alone in the house, you can take the child of your sister to come and help you out' or 'when you see the child of your brother suffer, you can always come and take it, right?' are commonplace in the village. The results of my 2007 household survey confirm the ease with which children circulate. As many as 49% of the 286 women responding to the question of whether they cared for children other than their biological offspring did so affirmatively (see Appendix VII). This is well above the estimated Cameroonian fosterage rate of 25% (Eloundou-Enyegue & Stokes, 2009, p. 282).[39]

Fosterage options and tactics defy not only notions of biological motherhood, but also portrayals of infertility-related suffering caused by an exclusive patriarchal order. Alber (2003, p. 492) has pointed out how flexible fosterage arrangements might in fact weaken patrilineal ties and virilocal norms. Thus, by widening the scope from narrow, predefined, hierarchical gender relations to relevant social bodies and social interactions in women's daily lives – within and beyond patrilinies – new light is shed on the suffering which is supposed to surround infertile women in so-called patriarchal societies. These insights allow for a critique of the 'narrow, distorted and presentist frame of individualized suffering' around infertility which has also been denounced by Hunt (2005, p. 432). Women's invocation of suffering here should be considered as inherently social, and therefore inherently situational and tactical – not *exempt of* but *exemplifying* their agency. The same holds for cases of abortion – to which we now turn.

Abortion: prevention and proof of suffering

As noted, social scientists, and feminists in particular, have often situated abortion practices within patriarchal, pronatalist frameworks condemning any limitation of women's fertility. Debates on abortion in Cameroon often invoke two other condemning discourses as well: a legal and a religious one. First, the voluntary interruption of a pregnancy is considered a criminal offence within a national legal framework. Considering the pronatalist population policy of Cameroon (see Chapter 1), it is unsurprising that its abortion laws are highly restrictive; section 337 of the Cameroonian Penal Code only

allows for abortion when a pregnancy results from rape, or when at least three professionals agree that a pregnancy endangers the woman's life. These situations rarely manifest themselves in practice, since rape is often kept secret – as Laura's story confirms – and the procedures to obtain the agreement of three independent professionals are long and complicated (GTZ, 2009; Henshaw, Singh, & Haas, 1999; Rahman, Katzive, & Henshaw, 1998). With most pregnancies thus falling beyond these two exceptional categories, almost all induced abortions are illegally conducted – and thus, formally, condemnable and punishable.

Second, every termination of a pregnancy is strongly condemned by the Christian church. To consciously interrupt a pregnancy is considered a moral offence against God given life, which should be protected and valued instead. Both abortions of foetuses that have already been formed or are considered to have a soul and terminations of pregnancies in the most preliminary stages of embryonic development are considered instances of murder by the church.[40] All those interruptions violate the individual right of the unborn to eternal salvation (Spruit, 1991). While on an international level, pro-choice movements have countered this strict dogma – even *within* the Catholic Church[41] – such lobby groups are virtually absent in Cameroon.[42]

Despite this environment of multi-level condemnation, induced abortions are widespread in Asung. Of the 223 pregnancy interruptions reported by 172 village women in my survey, 11% were indicated to be induced (see Appendix VII).[43] Numerous methods were cited: 60% of those 25 abortions had been provoked with indigenous products or chemical liquids, almost a quarter had been induced through clandestine curettages performed by biomedical staff in hospitals or informal neighbourhood offices, one was the consequence of a conscious overdose of biomedical medicines, and most of the other pregnancy interruptions had been brought about by the vaginal insertion of sharp objects or needles in order to open the cervix. All of these methods have also been applied by Laura, and were found in many other studies in Cameroon and elsewhere (Abega, 2007; Bleek, 1976, 1981; Calvès, 2002, 2004; Feldman-Savelsberg et al., 2008; Guttmacher Institute, 2003; Johnson-Hanks, 2002a; Renne, 1996, 2006; Schuster, 2005).[44] Furthermore, many respondents declared taking measures to prevent a pregnancy from developing right after sexual intercourse or when detecting a missed period. The concealment surrounding the first trimester of a pregnancy as described in Chapter 2 offers women the possibility, space, and time to secretly bring their still invisible and unconfirmed condition to an end – if at least they know of the above methods or have access to this knowledge. Many pregnancies are managed in the discrete period after conception rather than *a priori* prevented through contraceptives.

Numerous circumstances and motivations can make a woman decide to terminate ('the development of') her pregnancy. Often cited reasons include the young age, fear of parents, the desire to complete education or fulfil other aspirations, instability of premarital sexual relationships, non-recognition of paternity by the partner (see Chapter

4), difficult economic situations or, for married and older women, conjugal problems, extramarital pregnancies, health concerns, or birth spacing – reasons that can be found in the stories of my informants (including those of Yvette, Sophie, and Laura), as well as in other studies on the topic (Bleek, 1976, 1981; Calvès, 2002; CEPED, 2000; Feldman-Savelsberg et al., 2008; Guttmacher Institute, 2003; Henshaw et al., 1999; Koster, 2003; Renne, 1996, 2006; Schuster, 2005). These stories and studies show that abortion decisions are far from being made by autonomous agents acting *against* condemning systems – as celebrated by some feminists – but should be situated within the social bodies and structural constraints or horizons which make up the vital conjunctures around pregnancy termination. In fact, once examined within their social contingencies, abortion decisions seem to relate much less to (universalist and individualist) condemning discourses which are present in Cameroon and elsewhere, than to local idioms of suffering. These idioms of suffering appear in Gbigbil women's abortion narratives in several ways.

First, many abortions paradoxically ensue from a perceived clash between patriarchal ideals and encountered practices. As much as the patriarchal framework prescribes women to bear children for their husband's patrilineage, it prescribes men to take financial care of their wives and children – reciprocal expectations which are, as we have already seen in the previous chapters, often contradicted by conjugal fragility and insecurity in practice. It is in these circumstances that women might tactically invoke patriarchal ideals and idioms of suffering as justification for their abortion practices: with men (and their families) failing to assume their financial responsibility, suffering women may decide to neglect their prescribed duty of childbearing. Attention is thus diverted from what is expected from *women* – that is, children – towards the duties normatively prescribed for *men* – that is, the exchange of bride-price payments or at least financial care for their wives and children. The statement of my informant Angélique, who aborted her twins out of 'anger' against her neglectful husband and in-laws, is comparable to the complaints of many others:

> I aborted, because I was very angry with my husband and his parents. My family hasn't eaten anything! So I told myself, 'If I conceive another pregnancy, I will suffer a lot'. And we were already with two women in the house. My co-wife had already entered. Life was not good when I was all alone; how bad will it become when my husband has already two wives? No, I preferred to abort. My mother supported my decision. She has first suffered to bear and raise me. Now I bear my own children already and she suffers again with them. He should really thank her for her efforts. So I told myself and my family, 'I will not bear a child anymore before he pays his debt to my parents and treats me better as well'.

Angélique refers to an age-old patrilineal framework that takes bride-price exchanges between two families, and the resulting childbearing of a woman for the patrilineage of her husband, as a starting point. The absence of the fulfilment of these normative expectations in practice, as well as the appearance of a new co-wife in the household, are invoked by Angélique to account for her own suffering and that of her family. Suffering

then becomes a socially acknowledged incentive for further decision-making – in this case, inducing an abortion. Hence, abortions are resorted to in reaction to certain *realities* that clash with the norm, rather than in reaction to *the norm* per se. Contrary to what is often uncritically assumed, Gbigbil women do not terminate their pregnancies because they want to act *against* patriarchal norms, but precisely because they take these norms as a starting point – a sort of ideal – against which they interpret encountered practices in terms of suffering. Laura's repeated statement, 'I want to bear children, but not in this situation' indicates how norms and practices can become compromised through an idiom of suffering, and how patriarchal notions are tactically deployed in the process. Again, a discourse that supposedly oppresses women is transformed into a discourse that enables and entitles them.[45]

Second, aborting women also transform religious dogma from a condemning into a supportive framework. This was made clear to me when I was spending time with my informant Charlotte and her *maratre* mama Justine. I witnessed how they were paid a visit by Laura's uncle on his weekly 'door-to-door' preaching tour as a Jehovah's Witness. They offered the blind man a seat and interacted with him for a few minutes, but only pretended to listen to him afterwards; mama Justine continued her cooking, Charlotte started to put out her washed clothes to dry in the sun, and both women constantly yelled at children. Laura's uncle departed not long afterwards, but not without having left the message which he had probably intended to discuss at length:

> *Preacher*: I would like to talk about abortion today. Abortion is bad. You should know that sexual relationships are blessed by God. With the Grace of God, He will make sure that your sperm and the man's sperm form a child. At the moment your bloods cross, there is already a child. So if you abort, even a few days after sex, you kill a person. It's bad. And not only do you kill that person, but you also kill yourself. Or if you don't die, you will at least suffer a lot.
> *Mama Justine*: I would like to ask what to do if you conceive from a man who maltreats you?
> *Preacher*: In that case you should keep the child. For whom do you think this child will be?
> *Charlotte*: For the two of you, right?
> *Preacher*: But especially for the woman. She will profit a lot from her child. So if your husband maltreats you, you should leave him and endure. Because, if you would abort now, who will suffer? For whom is the suffering? For the woman, right?
> *Mama Justine*: The pain, indeed! But if I would have an abusive husband and I see I'm over time, I abort it! Why would I keep it? To suffer even more afterwards?

This interaction suggests that the practical social relationships – and their inherent power relations – in which pregnancies are conceived and contested are far more pertinent to abortion decisions than the existence of the condemning normative discourses of Christianity – or law, for that matter. Indeed, *if* women relate to a condemning supernatural force in the face of abortion practices, it is exactly the idiom of suffering within these social relations that they invoke. Laura's repeated claim that God will be able to *understand* her decision to terminate a pregnancy in certain situations is an example. Again, a condemning discourse does not seem to constrain women, or make them act

against it; rather, it is tactically suppressed, incorporated, or altered in favour of a discourse of social suffering.

But while abortions may be *induced* because of women's discontent with (present or future) suffering, they can also *induce* suffering. As the expressions of the preacher and mama Justine show, this '*souffrance*' is mainly considered to be physiological – with possible social implications. Far more relevant than legal or religious menaces seem to be the physical risks and damage of abortion practices (see also Bleek, 1976; Schuster, 2005). According to many informants, attempts to 'wash the stomach' or to interrupt what is considered a pregnancy – especially when this is done with indigenous medicines – could, due to their intrusive effects, 'burn the cord of children' or 'make the children flee from your belly'. It thus endangers a woman's reproductive future – if not her life (Koster, 2003, 2010; Renne, 2006). The fear of this danger is not unwarranted: the most recent statistics from the Cameroonian Demographic and Health Survey (DHS) in 2004 show a maternal mortality rate of 669 per 100,000 live births (Barrere, 2005, pp. 232-233), of which a considerable part is probably caused by abortion-related complications.[46] Further, in a setting where women's fertility may always turn out to be wanted or necessary in the future, any damage purposefully inflicted is heavily frowned upon as unwise – a form of '*politique*' possibly leading to future suffering. Reactions to several cases of abortion-related deaths in Asung tellingly ranged from pity and lamentation of women's marital and reproductive suffering (which must have caused the abortion attempts), to commentaries like '*elle n'était pas sage*' ('she wasn't wise'), criticizing the risky reproductive behaviour that resulted in suffering and death.

Idioms of physical suffering *after* abortion may also be deployed on purpose – especially when the abortion attempt should remain unknown to outsiders. As noted in the previous chapter, induced abortions can be presented as spontaneous miscarriages. Related idioms of physical suffering divert attention from questions of culpability; they convey an image of innocence that is often warranted in a context where both marriage relationships and fertility stakes are uncertain and contested. Further, like in cases of infertility, idioms of suffering can inform, and raise (financial) support for, tactical treatment itineraries. Since induced interruptions are considered to provoke more and heavier blood loss than spontaneous abortions or childbirth (see Chapter 3), both indigenous and biomedical treatments (such as blood-producing concoctions, vitamin substances, cleaning purges, or anti-inflammatory biomedical injections) are deemed indispensable to replenish the blood reservoir and to prevent further reproductive suffering. Post-abortion care – officially included in Cameroon's 2001 'Policy and Norms of Reproductive Health Services' (see Chapter 1) and aiming to alleviate abortion-related suffering *irrespective* of its provenance – is designed to allow for such 'hidden' instances of health-seeking. Practically, however, post-abortion services seem not only materially limited – especially at the level of the village dispensary – but also largely unused by Gbigbil women. As the local doctor admitted to me:

> Depending on the stage of the abortion, I can treat it. In case of simple contractions, I can try to calm them down. And if the foetus comes out already, I can treat it like a normal delivery; it's simple. But if the woman bleeds, I have to refer her to Bertoua for an ultrasound to see the position of the placenta. Similarly, in terms of post-abortion care, I can only offer her some medicines if she doesn't bleed anymore. If she is still bleeding, I again have to refer her to a specialist. But it is rare that women come here after their abortions. They prefer to give birth at home and don't come here anymore if things went okay. I only receive complicated cases. What also happens is that women *do* ask their husbands for money for treatment because they claim to suffer so much, but put it in their pockets and never come to the hospital.

The doctor went on to cite the case of my informant Géraldine, which I had closely followed. When she had lost her pregnancy of four months, an enormous commotion developed around the 5,000 CFA Francs (around 7.5 Euros) that she had demanded from her husband for post-abortion care and alleviation of her suffering. While she claimed to me to have spent this money on cheap medicines from ambulant sellers and 'some good food since you should eat well after a miscarriage', others – including the doctor, who had prescribed some medications but never saw Géraldine back for treatment – blamed her for having used her husband's contribution for her own purposes. Her subsequent request to me to finance her curettage was met by the warnings of others that she not only wanted to 'eat' my money, but was also probably deploying an idiom of pain and suffering to cover the fact that she had induced this pregnancy interruption herself. Indeed, women's complaints about heavy blood loss, abdominal pain, or other forms of suffering after pregnancy interruptions are likely to encounter the suspicions of outsiders, who are always aware of this possible intentional aspect underlying interrupted fertility (see Chapter 4). Suffering and agency thus relate to each other in complex ways; like cases of infertility, reproductive interruptions are never exclusively associated with either the one or the other.

Conclusions: the stakes behind shared sorrows

This chapter has illuminated some common grounds that underlie the navigation of the various reproductive conjunctures that have been mentioned in this dissertation. Its aim was not to reduce the complexity of women's particular processes of navigation of reproductive conjunctures – which have been shown to vary along with their socially constituted pathways and their personal projects, as well as other particularities. Rather, it has attempted to reveal some discursive mechanisms that underlie multiple modes of fertility management. These discourses touch on women's own conceptualizations of their capacity to give direction to reproductive conjunctures, to 'optimize the occurrence of promising novelties' (Guyer, 2005, p. 379), or to exploit local 'habits of pragmatism' (Lock & Kaufert, 1997, p. 2) in order to pursue their personal projects. The apparently opposed stories of a childless village *mama* and an aborting urban youngster have revealed how women deploy this 'shared narrative groundwork' (Gammeltoft, 2006, p.

595) in comparable ways while navigating the amalgam of normative frameworks, social specificities, material constraints, reproductive aspirations, alternative projects, and hopeful horizons that come together in vital conjunctures.

This common narrative ground encompasses what I have called paradoxical portrayals of powerlessness. Idioms of suffering, fate, resignation to religious dogma, or submission to patriarchy paradoxically create room for tactics (de Certeau, 1984); under the veil of powerlessness, women exert their '*politiques*' – within their marriages, within their families, or within diverse health care systems. Dominant discourses about distress, religion, gender, or patriarchy – in terms of which women's reproductive experiences have often been understood by outsiders – are appropriated and reinterpreted in order to make one's voice heard and pursue or justify one's projects without upsetting the dominant order. Sometimes – when mobilized as 'hidden transcripts' (Scott, 1990) of female worth and power, or when deployed in formal institutions advocating women's empowerment – such idioms of powerlessness enable women to actually *challenge* the dominant framework and gain power in the process. Irrespective of its particular manifestation, however, this 'shared narrative groundwork' always reveals a dialectical relationship between agency and suffering; as Gammeltoft (2006, p. 600) has pointed out, 'suffering implies agency just as agency implies suffering'. Contrary to common assumptions, in Eastern Cameroon this holds for both abortion and infertility, and for women with rural and urban aspirations alike.

By drawing attention to the commonalities in the ways in which Gbigbil women negotiate their (overt or covert) projects within the social order around them, this chapter has touched upon some interpersonal dynamics at play in women's reproductive navigation. By showing that such negotiations are subject to 'judicious opportunism' – contingent on the particularities of the moment and the social surroundings – it has at the same time illuminated the individual inventiveness within changing webs of interrelationships. Further, the stories of mama Rosie and Laura have shown how material bodies (refusing pregnancy conception and pregnancy interruption, respectively) are also at play in fertility management and its outcomes. What, then, can be said about the role of the social, the individual, and the body in reproductive conjunctures? What interrelations and mechanisms of reproductive navigation can we discover in the midst of contingency and controversy? The following, concluding, chapter aims to answer these questions.

CONCLUSION

August 2009. Time to go home. After fifteen months of fieldwork in Asung, I depart from the village with a mixture of sadness and satisfaction, and board a minibus ready to take me and many others on the long and bumpy ride to the capital. In Abong Mbang we make our first stop, which is also the last one in the East Province. Our over-crowded bus immediately attracts a group of young Cameroonian girls who slowly stride alongside its open windows, doughnuts, banana chips, roasted nuts, and peeled oranges on the plates above their heads. A man sitting next to me buys some peanuts from a young girl, who looks him straight in the eyes before moving on, hissing to attract other customers. I hear how, with a tone of indignation, the man exclaims to his companion:

> Did you see how she was making eyes at me [*elle me faisait les yeux doux*]? Girls here in the East Province are not children anymore. They know men at the age of eleven. They are ready to seduce men and teach them a lesson in bed. And they want to give birth quickly and abundantly. I tell you!

As we leave the East Province and its sandy roads behind us, I remember how often I was confronted with this image of East Cameroonian women during my research on pregnancy interruptions in the area. Despite its long, well-documented history of high infertility, both Cameroonians and ethnographic sources consistently report abundant sexual activity and reproduction in this rainforest region. Motherhood, they claim, is what matters here. With my Gbigbil informants still fresh in mind, I note how this view differs from the stories I had heard in Asung. Women's narratives there not only revealed other reproductive experiences, but also an amalgam of alternative ambitions. This thesis has been an effort to commit these narratives to writing, and to shed light on the dynamics, desires, and decisions around interrupted fertility.

The longitudinal character of my research – spread over five years – allowed me to follow my informants over time and to observe and discuss the many developments in their reproductive trajectories. This focus on, and participation in, women's life courses enhanced my understanding of their pathways and projects – that is, their ambitions, aspirations, and hopes (Ortner, 2006) – at different points in time. I saw that women's pathways and projects were constantly changing – entailing many moments of possible redirection that I, following Johnson-Hanks (2006), have called 'vital conjunctures'. Indeed, in a context where both immediate social interactions and larger social structures

are pervaded by uncertainty and unpredictability, the particular reproductive conjunctures that were central to this study are only part of a much larger and continuous spectrum of unexpected happenings that characterized daily life in this Cameroonian village.

Not surprisingly, then, the stories of my informants proved to be enormously diverse and in need of contextualization within Asung's local moral worlds and beyond. Yet, rather than concluding that everything is just variable and socially contingent, my aim was to try to trace some meaningful patterns in how women make sense of and give direction to their reproductive interruptions. What conclusions can we draw about reproductive navigation on the basis of the stories of Yvette, Sophie, Laura, mama Rosie, and the many others who appear in this dissertation? How do the concepts of 'vital conjunctures' and 'social bodies', as identified in the introduction, aid our insight into *how* and *why* Gbigbil women make their decisions around reproductive interruption? And how are the outcomes of such potential turning points informed by 'specific forms of sociality' (Guyer, 2005, p. 379) or by modes of individuality and corporeality?

This conclusion ventures some answers to these questions. The first section discusses how different forms of sociality in Asung affect women's reproductive ambitions; the second describes the possibilities individual women have to inventively assert their ambitions at moments of pregnancy interruption. In the last section, I point out how the body itself is involved during the 'periods of potential transformation' (Johnson-Hanks, 2006, p. 22) that evolve around interrupted fertility. Taken together, these discussions of sociality, individuality, and corporeality will inform my concluding reflections on what I, with reference to Vigh (2006), have called 'reproductive navigation'.

Ambitions affected: on intercontingencies and social stakes

This study has shown that pregnancies and their interruptions are *social* affairs in East Cameroon. The very definition of a pregnancy, its appropriation by others (all with different stakes and interests) once it becomes visible, its management, and the perceived causes and consequences of its interruption are all socially constituted – and therefore, at times, also socially contested. A similar sociality pervades the foetus as well. Not only are foetal bodies believed to be made up of the essential physical substances (blood and force) of social others, but their contingent development and demise are also subject to social definitions and negotiations. Both pregnant women and their unborn children can thus be said to have *social bodies* in the sense that they acquire meaning within, and are constituted by, the social (inter)connectedness of Gbigbil daily life. In our exploration of patterns of reproductive decision-making in Asung, the question is how this inherent sociality affects women's navigation of their reproductive conjunctures. In terms of Jane Guyer's proposition, we need to examine whether and how 'specific forms

of sociality' possibly 'optimize the occurrence of promising novelties' that women explore during vital conjunctures. Which social factors and interrelations affect Gbigbil women's reproductive pathways and (possible) projects, as well as their decisions to (not) alter these during moments of interrupted fertility?

Before delving into this question, it should be noted again that Gbigbil women's pathways and projects are multiple. So are the 'promising novelties' that present themselves, inspiring new projects or the redirection of previous pathways. To recount all the horizons, options, and directions that Gbigbil women explore within reproductive conjunctures – themselves multiple and situated in wider, ever-changing historical, political, and economic conditions – would be an endless enterprise. However, in broad terms, the pathways women embark upon can lead towards rural or urban respectability, and the most relevant projects that come into play around pregnancies and their interruption concern (the embracing or rejection of) motherhood and/or wifehood. In conjunctures around interrupted fertility, women typically make decisions regarding the initiation/continuation of motherhood (i.e. trying to conceive again or taking a 'rest'); the initiation/continuation of a (possible) marital relationship (i.e. staying with one's partner, or leaving to one's family or another man); and the continuation/alteration of broader pathways (i.e. clinging to one's formerly imagined future, or switching focus and possibly location altogether).[1]

These decisions, in all their possible variations, are far from deliberate, 'free' choices. Women's pathways and projects, and their potential redirection in light of the constraints and horizons brought about by fertility interruption, are inherently related to several social configurations. These 'specific forms of sociality' are neither mutually exclusive nor always equally relevant. Yet, taken together, they form an insightful repertoire of significant interrelationships underlying the reproductive navigation of Gbigbil women.

First, a woman's position within a wider body of kinship relations affects her pathways and reproductive and marital ambitions over time. It matters whether a woman is her mother's first or last daughter; whether she was born in or outside marriage; whether she grew up in her own patrilineage or among maternal uncles; and whether she has few or many siblings ('from the same womb' and/or 'from the same father but different mothers'). Women who share the former characteristics – first daughters or ones with few sisters, born and raised within their own patrilineage – are more likely to have relatives involved in their reproductive affairs. One only needs to recall the stories of Laura, who was the only daughter of her parents, and Yvette, who grew up with her mother's maternal uncles, to see the difference. With their premarital reproduction considered an extension of their parents', and that of the patrilineage, women like Laura are more likely to be free (or even pressured) to bear children before marriage – and to give these children to their own mothers or fathers. The marital lives of such women are also more easily influenced by the interests and wishes of family members. As first or

single daughters are highly valued for the bride-price they are expected to bring to the family, their relatives often pressure them to 'enter' into and 'endure' marriage, and to bear children to encourage the husband and in-laws to fulfil their financial obligations. In the absence of bride-price payments, relatives will more easily enter into conjugal disputes and accept their daughters coming home to 'rest' after a reproductive interruption; they may even advise them to abort pregnancies or force them to leave the marriage altogether. In cases of fertility interruption, the decisions of women like Laura are more likely to be influenced by the wishes of relatives – especially their mothers.

Second, the position of a woman's kin group within the village determines which pathways and ambitions are feasible. In the current atmosphere of political and economic patrimonialism, daughters from extended families in which important persons enjoy informal political power or formal employment are better positioned to profit from the established financial and social capital. As was shown in Sophie's story, such daughters are more likely to embark upon pathways towards urban respectability from a young age – through schooling or well-off foster parents in the city, for instance. In cases of pregnancy interruption, these women may be less inclined to cling to motherhood and wifehood – and be supported by their family members and other villagers in this deviation from rural respectability. They may also enjoy greater access to *financial* support to pursue alternative ambitions and to seek medical treatment for their fertility interruptions.

Third, social connections to urban zones – whether through family members or through strategic alliances such as those with *big fish* as described in Chapter 4 – can affect a woman's pathways and reproductive or marital ambitions. Formal education and exposure to urban horizons can change visions of womanhood, wifehood, and motherhood, while acquaintance with biomedical health models and means of contraception and abortion – formally taught at school and informally shared among women – enables one to prevent or interrupt pregnancies and to prioritize other aspirations. This does not necessarily mean that the reproductive discourses and tactics of such women differ from those who remain in the village. Nor does it mean that they are more 'empowered' than their 'suffering' rural sisters, as argued in Chapter 5. What it *does* mean is that women with access to urban zones may have a wider frame of aspirations and possible horizons, and thus more options at hand in their reproductive conjunctures.

Fourth, a woman's reproductive navigation depends on the particularities of the sexual or marital relationship with the (potential) father of the child to be born. Chapter 4 showed that it is not so much the volatility or stability of the relationship – as both informal and formal unions are highly fragile – but her partner's (perceived) ambitions and reactions to the pregnancy (interruption) that inform a woman's marital and maternal projects, her imagination of rural or urban futures, and her course of action within reproductive conjunctures. Especially when her partner recognizes paternity and is

willing to commit financially after her pregnancy has proven her fertility and worth as a (potential) wife, motherhood and marriage can become immediate priorities, before and after the interruption of a pregnancy. In the opposite case, where reciprocity and signs of commitment are absent, pregnancy interruption may open up other horizons. Indeed, the presence or absence of (parts of the) bride-price – given by the current or previous partners – is often a decisive factor in a woman's decision-making.

Fifth, a woman's reproductive navigation is influenced by the proximity of unrelated others with stakes in the children born to a particular relationship. The co-presence of in-laws – in virilocal marriages where women live with their husband's kin – can lead to increased *control* and *encouragement* of reproduction as these in-laws are generally eager to see their patriliny expand. Fertility interruptions that occur in such a setting will usually be surrounded by more suspicion, conjugal complications, and involvement of in-laws than those happening in neolocally residing couples; consequently, a woman's navigational decisions will be more influenced by the wishes and demands of her husband's kin. The existence of co-wives may also affect a woman's reproductive management since these female competitors are often experienced as a *threat* to continued reproduction. While the presence of co-wives can in fact strengthen a woman's marital and motherhood ambitions, it can also make her lose interest in a particular conjugal arrangement and abandon its associated aspirations. Either way, fertility interruptions occurring in a context of direct female competition are generally surrounded by more contestation and explicit reconsideration of one's previous pathway and current ambitions. The happening is almost certain to become an *event*; we only need to recall the differences between Sophie's two pregnancy interruptions (happening in the absence and presence of a co-wife, respectively) to see this.

Finally, the possibility of certain pathways and projects, and their redirection during reproductive conjunctures, is informed by a woman's personal reproductive trajectory, and the social status she derives from it. While the absence of children and 'mother' status may allow young women to focus on ambitions unrelated to maternity – education, employment, small-scale trade, relations with affluent sexual partners – too prolonged an absence of pregnancies may actually heighten a woman's aspirations for maternity and marriage. Although pregnancies do not necessarily imply motherhood or marriage – thus offering women the possibility to remain focused on alternative projects – social pressure to find a suitable husband and take care of one's children increases with the number of childbirths. Thus, over time, marriage and motherhood are likely to increase their saliency as aspirations directing women's reproductive navigation. Nevertheless, ambitions may change again when a history of successful and respectful childbearing has been established. The presence of (live) children confirms one's worth as a woman, (potential) wife, and mother, and can thereby open up new horizons that are less related to maternity. In cases of interrupted fertility, this proof of (previous) willingness to bear children can contribute to an image of innocence – and leave women's

conjugal ambitions intact. In contrast, a long history of unsuccessful fertility and/or marriage attempts can foreclose marital options or diminish marital and maternal ambitions. Women with such experiences more easily turn their focus to urban horizons or virtues unrelated to motherhood. This was seen in Nadine's explicit aim to move to the city after several failed marriages and repeated child deaths in Asung as well as Mama Rosie's emphasis on her good character and organizational skills rather than the absence of children in her life.

What does all this mean for our understanding of women's reproductive navigation in Eastern Cameroon? Obviously, the different social configurations affect women's reproductive trajectories in different ways: while some are enduring and define which pathways and projects are feasible for women from the outset, others change over time and inspire women's projects at particular moments. Yet, all of them define the availability of options in reproductive conjunctures and, as such, form *possibilities* and/or *constraints* to women's realization of their ambitions. Reproductive decision-making, then, is a socially contingent affair, embedded in different forms of sociality and power relationships. And since the influence of relevant others – parents, siblings, partners, in-laws, co-wives, other villagers – in a particular conjuncture depends in turn on *their* life contingencies, *their* previous pathways, and *their* stakes at that moment, one could further argue that decisions are *inter*contingent.[2] In other words, life stories intersect; women's navigation never happens independently from the navigations of those around her. The outcomes of reproductive conjunctures are not the predictable result of individual deliberation and design, but the contingent result of the involvement of social others, and of the ways in which women constantly reconfigure their choices in relation to these others.[3] Unsurprisingly, this is particularly true for navigations around pregnancies and their interruptions, which are *inherently* social affairs.

Yet, all this does not mean that women lack individual aspirations or room for individual 'tactics' (de Certeau, 1984) that enable them to manipulate the social order. In the reproductive navigation of Gbigbil women, structured sociality is always confronted by equally present notions and expressions of individuality – to which we now turn.

Ambitions asserted: on individuality and tacit tactics

The life stories in this study have shown how Gbigbil women – whatever their background, marital status, social network, or future aspirations – find room to manoeuvre through complex social situations when striving after their own goals. Women often have clear ideas about what is at stake for them and the desired outcomes of their vital conjunctures – even if such ideas are sometimes tactically disguised under an idiom of powerless suffering. Indeed, it is exactly through what I have called the 'paradoxical portrayal of powerlessness' that women find individual and inventive ways to assert their interests and try to influence the course of events. Idioms of suffering and

submission are (re)interpreted and used in such a way that they allow women not only to comment upon the dominant order but also to manipulate it and tactically attain their own (reproductive) goals. Thus, rather than understanding women's complaints of powerlessness as reflections *of* oppressive patriarchal regimes or of other forms of social subjugation, I have argued that we can comprehend them as 'hidden transcripts' (Scott, 1990) reflecting *on* this order and enabling individual reproductive management within it. Such hidden transcripts, as well as some less hidden challenges to the dominant order, are used by women in both urban and rural areas alike, pointing to a common narrative ground drawn upon by individuals irrespective of their particular social context. But given the inherent sociality of reproductive experiences and decisions, how should we understand these individual tactics?

First of all, it should be pointed out that notions of individuality are not unheard of in the social fabric of Asung's daily life. In fact, they have a long history in this region, where social relations prior to colonization were organized according to principles of separation and resettlement: once individual men attained a certain age and independence, they would leave their kin group to found an autonomous village (and thereby a new patrilineal segment) elsewhere in the rainforest. Even if a central authority beyond the village level was often lacking, constant power struggles within groups were certainly not absent. Indeed, on the basis of personal talents and characteristics, men attempted to enlarge their group of followers and gain wider power and influence – which could easily be lost to others (see Chapter 1). Social organization was based upon what Guyer (1996, p. 7) has described as a 'self-valuation/realization process whereby the singular pathways of personal expertise were competitively/performatively valued and validated'. Individuality *mattered* for the attainment of social status and power.

While this self-realization could historically only be achieved by adult men, nowadays it finds its expression in all stages of the Gbigbil life cycle, for men and women alike. The foetus, once it has attained enough force (*ngul*), is already believed to be an agent with its own wishes, initiatives, and realizations. Newborn children are carefully examined for individual traits; later in life, they are encouraged to exploit their inborn talents to differentiate themselves from others. Women are constantly preoccupied with their personal 'force', needed to direct their (reproductive and marital) pathways and to pursue their particular projects. Individual inventions and improvisations are even considered constitutive of good and successful womanhood, as Chapter 5 has shown. Self-realization – and its attendant preoccupation with one's pathways – is thus a historically rooted 'social asset' (Guyer, 1996, p. 6) that is highly valued in Asung's contemporary social fabric.

As for the relationship between such particular pathways and social structures, Guyer (1996, p. 23) claims that 'to the degree that the creation of a life trajectory is a prominent principle in the social organization of assets, to the same degree will agency and improvization have structural salience'.[4] Indeed, this study found Gbigbil women's

focus on individual inventions and interventions to be related to some structural configurations that make up their daily lives.

First of all, women's valuation of individuality is a result of their ambiguous positions as women and wives in society. Due to long-standing virilocal and patrilineal norms, and the reality of bride-price payments often not being honoured, women are not only considered 'outsiders' in their partners' households, but are also often moving between multiple, fragile partnerships and their own families. This situation both demands improvisation from women and offers them space for manipulation.

Second, *beyond* the marital framework, women and men face structural circumstances that require constant individual creativity. The fluid and uncertain 'terrains' described in Chapter 1 can only be navigated through individual improvisation. In the present era, when the economic crisis seems never-ending, (urban) opportunities are rare and unpredictable, the practice of witchcraft is believed to be omnipresent, and long-standing norms of social interaction are often breached, 'horizons' may vanish as quickly as they appear. The mechanism underlying women's navigation of their vital conjunctures is therefore one of *judicious opportunism* (Johnson-Hanks, 2005) – a matter of pragmatic improvisation rather than following a pre-established, rationalized itinerary. Instead of having clear trajectories in mind, my informants take promising chances – and appeal to promising discourses and explanatory models. Perhaps paradoxically, this improvised decision-making in the inherently *social* domain of reproduction is often an *individual* affair, with women exploring and evaluating promising horizons individually, inventively, inconsistently – and often also secretly.

Individual initiative has often been portrayed as a source of tension in Eastern Cameroonian communities, which have long been pervaded by clear ethics of sociality and egalitarianism (Copet-Rougier, 1987; Geschiere, 1982, 1997b, 2003; Geschiere & Konings, 1993; Guyer, 1996; Laburthe-Tolra, 1981). It is hardly surprising that this tension between individuality and sociality is especially evident in matters of reproduction and its interruption – in this Gbigbil village and elsewhere. By ensuring continuation of the social order and by imbuing parents with social status and power, nothing is more *social* than reproduction. Yet, nothing is more *individual* either. Especially in a cultural context where women are considered outsiders to the patrilineage to which their children officially belong, and where the first few months of pregnancy are shrouded in silence and denial, fertility remains largely in the hands of individual women. It is this very individuality and privacy that offers pregnant women a secret space for decision-making – even if these decisions are never 'free choices' but informed by social interests and horizons. Secrecy – through the *individual* pregnancy interventions it enables – is often crucial for attaining one's *social* goals; it creates room for social navigation. Due to this potential tension between the individual experience of and influence over fertility on the one hand, and social norms, interests, and expectations on the other, reproduction – and even more its interruption – is an extremely ambiguous affair.

This ambiguity finds its clearest expression in the many accusations of witchcraft that follow cases of interrupted fertility. The idiom of witchcraft allows people to comment on individual forms of accumulation (and all other anti-social practices that favour social inequality and power hierarchies) that contravene the region's long-standing ethics of social egalitarianism.[5] To accuse someone of the witchcraft variant *ivū*, for instance, is to insinuate that this person's actions are led – through a dominant occult force – by an enormous individual appetite for blood, flesh, and wealth that is detrimental to social, and especially familial, stability. Tellingly, such accusations surround fertility interruptions in particular. That *both* pregnant women *and* their social surroundings might possess *ivū* and harm the developing baby points to the tension between sociality and individuality in reproductive matters. On the one hand, women's conviction that malevolent witches may pose a threat to their pregnancies shows the inherent sociality of reproduction, possibly endangered by individual competitors in the social world. On the other hand, the many suspicions that surround the women *themselves* once their pregnancy is interrupted shows how reproduction is at the same time considered an individual affair, amenable to negative influence by some hidden anti-social power in one's belly. The many witchcraft stories that appear in this dissertation should thus be read as reflecting a local and historically embedded preoccupation with forms of individuality that have long been recognized but also feared – in society in general, and in reproductive matters in particular (see also Geschiere, 1997b).

Apart from the ambiguous associations with supernatural forces, fertility interruptions also induce women to worry about their own natural, bodily force (*ngul*). These idioms of *ngul* represent another set of commentaries on the complex interrelationships between individuals and their social surroundings. One's amount of force is considered individually unique and contingent; it is innate and subsequently altered through life experience. Next to constituting an individual's physical strength, *ngul* seems to denote one's power to adapt, to make decisions, to alter ambitions, and to navigate unforeseen vital conjunctures within constantly changing social situations. As such, it is directly related to one's agency. At the same time, it reflects one's status within, and interconnection to, the social world. As Chapter 3 has clearly shown, most complaints of 'lack of force' tellingly come from those who are deprived of a social network or social acknowledgement of one's identity as a woman, wife, or mother. Due to *ngul*'s direct link to childbearing, complaints of forcelessness can moreover be critical commentaries on the social norms to give birth, or on the lack of social support and care after delivery or pregnancy interruption. Such portrayals of physical powerlessness can, as I have argued, paradoxically create room for individual manoeuvring within the very social order that is implicitly denounced. As such, complaints of forcelessness can be used to justify individual decision-making that runs counter to social norms and expectations. Yvette's firm resolution to resort to contraceptive use and abstain from sexual relationships with her husband after her body had grown 'old' and 'weak' is a case in point. Idioms of force

thus form a complex commentary on existing tensions between individual and social affairs; that reproductive experiences are translated into preoccupations with *ngul* shows how fertility forms the ambiguous crux between these two domains.

By highlighting these tensions around fertility interruption, this study unites stances in a debate that has long divided those who focus on the social dependency and interconnectedness of reproductive decision-makers, and those who stress the potential for individual autonomy in fertility matters. I have shown that, at least in the Gbigbil case, one does not exclude the other. Women can be intrinsically tied to social others and at the same time enact forms of individuality that are rooted in, and even encouraged by, that same social order. These dynamics are best captured through a conceptual combination of 'vital conjunctures' and 'social bodies' – as each of these terms makes up for shortcomings in the other. The concept of the vital conjuncture (Johnson-Hanks, 2006) allows us to lay bare the minutiae of individual decision-making *within* social contingencies but tends to overlook the *inter*contingencies and sociality of agents as well as of the pathways and projects that guide their navigation; the concept of the social body as proposed by Africanists (Piot, 1999; T. Turner, 1995) stresses exactly this state of interconnectedness but often ignores its impact on individual decision-making. Taken together, they allow for a more comprehensive view of the tactics of reproductive navigation.

Such comprehensiveness matters for the anthropological study of reproduction, as it highlights the intricacies of the actual happenings around critical reproductive moments without falling into the trap of reducing these to abstract dichotomous categories such as the ones between 'social' and 'individual' or between (social/structural) 'suffering' and 'agency'. It thus allows us to come closer to the everyday lived experiences of women who carry, avoid, interrupt, and lose pregnancies within the local moral worlds that surround and constitute them. Yet, if *lived experience* is what we want to describe, we need to consider another aspect that is often ignored by both this individual-social dialectic and the concepts – 'vital conjunctures' and 'social bodies' – proposed to capture it: namely, the *material* body. The following section points out why focusing on the material body is particularly relevant to the study of fertility interruption, and how it enhances our understanding of women's navigation of the conjunctures around these interruptions.

Body basics: new notions of navigation

To say that fertility-related pathways and projects are both *socially affected* and *individually asserted* is to point to the different (inter)personal dynamics that underlie women's navigation of reproductive conjunctures; to say that the tensions between the two are often verbalized in symbolic idioms of metaphysical powers and physical powerlessness is to point to the meanings women give to these (inter)contingencies. But

this is not to say that the actual *physical* experiences around fertility are to be discarded in the study of reproductive meanings and management. Even if bodily concerns – like the ones about physical force – constitute social commentary, bodies also matter *in themselves*. As Margaret Lock (1993a, p. 136) once stated, 'The question of the body requires more than reconciling theory with practice. It brings with it the difficulty of people both having and being bodies'.[6]

And these bodies sometimes appear to have a will of their own. Especially when it comes to fertility and its interruptions, they do not always do what is wanted of them. The stories in this dissertation revealed many possible unanticipated situations: in Chapters 2 and 3, Diana and Yvette tried to 'prevent a pregnancy from entering' but nevertheless missed their periods repeatedly; Chapters 4 and 5 described how Sophie, Nadine, and Laura attempted to 'prevent a pregnancy from developing' but failed as their interventions to interrupt foetal force-filling had no effect. The stories of mama Rosie and Yvette showed how both women, while young and desperate for children, were suddenly confronted with bodily states (infertile and 'old', respectively) that made any future reproductive success highly unlikely. Bodies like the ones of Yvette and Celestine unexpectedly collapsed during deliveries or after pregnancy interruptions that turned out to be more 'complicated' than anticipated. Such physical signs and surprises affect the meanings women attach to their bodies and the fertility-related projects they pursue in their lives. Reproductive decision-making is therefore not only possible or constrained because *others* and *individuals* act, but also because *bodies* act.

Such an acknowledgment asks for an even *more* comprehensive understanding of reproductive navigation – one that adds the primacy and praxis of the body (or 'body basics') to the individual-social dialectic discussed above. The body does not only enable or constrain women's navigation, but it needs to be navigated *itself* as well; it both *directs* and *demands* navigation. Since acting bodies are unpredictable, women have to constantly manage the broad range of options, outcomes, and obstacles that their bodies present to them. They are confronted with a material world in which anything can happen – the incoherent logics of the body varying between women and over time. Judicious opportunism is thus as much at play at the level of the body as in the uncertain and unpredictable social situations that Gbigbil women encounter.

This bodily navigation – individual and intimate in nature – is always dialectically related to *social* navigation as women try to align their unpredictable bodies with their social projects. Women constantly supervise, manipulate, and redirect their bodies – and their unexpected workings – in order to successfully navigate vital conjunctures and socialities. They do so within certain limits, however; methods to redirect bodily workings are neither endless, nor always effective in the face of the body's inherent – and at times, persistent – capacity to become pregnant or to release a pregnancy. Nadine's story in Chapter 4 is a case in point: after trying in vain to abort her unexpected pregnancy, which did not fit with her plan to find a rich husband in the city, she used her pregnant state as a

potential incentive for three appointed 'fathers' to engage – an alternative route into the urban marriage she was aspiring to. By refusing to release the foetus, Nadine's body circumscribed her reproductive navigation; at the same time, this very bodily condition was inventively transformed into a new project on Nadine's pathway to urban respectability.

Such body basics contribute to our understanding of reproductive decision-making in ways that the concepts proposed above can not. 'Acting' bodies have been largely ignored in the notion of vital conjunctures and they are more than only social bodies constituted by interrelationships as Africanists like to stress. They are the very basis of reproductive experiences and, through it, form a bridge between individual decisions and social situations. In cases of interrupted fertility, this nexus between body, self, and society is disturbed and re-evaluated. Physical well-being, personal pathways and projects, and social situations are possibly redefined in the process; reproductive interruptions can turn into events or be purposefully downplayed as non-events. Only when we acknowledge this interplay of the body, the individual, and the social can we come to fully understand the meanings and management of interrupted fertility.

Such an understanding of reproductive navigation brings new insights to existing studies and interventions in the domain of reproductive health. First, it allows us to see beyond the analytical dualities that underlie current thinking on interrupted fertility. The complexity of Gbigbil women's reproductive navigation questions common assumptions about early and late pregnancy interruptions (Chapter 3), spontaneous and induced abortions (Chapter 4), and suffering and agency, often linked to rural and urban realms respectively (Chapter 5). Due to the tensions between body, self, and society that underlie interruptions of fertility, these categories (addressing physical, individual-intentional, and socio-structural issues respectively) are far from clear-cut in everyday practice. This study has revealed that it is their very *blurriness* that makes experiences of fertility interruption in Asung so ambiguous. At the same time, this study has shown how these very ambiguities allow women to pragmatically turn to (partly hidden) possibilities and differing discourses. All vital conjunctures around interrupted fertility are 'socially structured zones of *possibility*' (Johnson-Hanks, 2006, p. 22) – because they generate socially structured zones of *ambiguity* that women can pragmatically navigate.

Second, the comprehensive conception of reproductive navigation proposed in this study sheds further light on these pragmatics – which have also become a focus in the recent (and valuable) body of literature on 'reproductive politics'. Inspired by feminism and Foucault, this recent work emphasizes the power relations and discursive body politics that infuse reproduction. Bodies are certainly present in these ethnographies, but largely as arenas in which multi-level power relations and discursive struggles are played out. While this study showed the human body to be a site for 'negotiating contradictory forces' (Ginsburg & Rapp, 1991, p. 314) and a 'forum for the expression of dissent and loss' (Lock, 1993a, p. 141), the body is also more than this. In

being active and unpredictable agents *themselves*, material bodies both direct and demand pragmatic management. A broader understanding of navigation that incorporates the workings of material bodies will bring back into view the 'body basics' that risk being overlooked in overly political analyses of reproduction.

Finally, the conceptualization of reproductive happenings and decision-making proposed here questions many of the ideas informing the reproductive health programs and policies implemented in present-day Cameroon and elsewhere. The past decades have witnessed growing international attention to, and advocacy for, women's reproductive rights and choices. But implicit assumptions about how decisions are made seem to be at odds with practical realities as observed in Asung. The stance that women should *a priori* be able to control their fertility and fertility outcomes becomes untenable once we acknowledge that personal reproductive ambitions are always inherently related to largely unpredictable socialities *and* physicalities. Contrary to the stability that family planning campaigns attribute to women's fertility desires, this study has shown that reproductive projects change with the hopes and horizons that emanate from women's individual and social bodies. As such, this study has also highlighted how certain situations are initially *not* chosen but eventually accepted; how some choices are *not* made or *impossible* to make despite one's aspirations; how certain options are explored but abandoned again; and how some decisions forcibly ensue from the unexpected actions of women's bodies or interactions with other social actors. Women's reproductive pathways can be strewn with obstacles or lead to hopeful horizons. The directions women take along the way are less a matter of control than the result of a contingent interplay of connectedness, creativity, and corporeality.

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Undoubtedly, many more dynamics than the ones suggested above could be explored in further research on reproductive interruptions. My trip out of the field as described above was by no means a definitive one, leading to final conclusions without need for return or reconsideration. Perhaps the gradual opening up of ambiguous moments of interrupted fertility can itself be considered a 'vital conjuncture' – full of possible entrances and new explanations with the ability to transform previous lines of thinking on the subject, both scientific and popular. The exploration of new horizons will undoubtedly lead to deeper understandings of interrupted fertility in the future. With reproductive interruptions being *vital* conjunctures that can have life or death consequences – as witnessed by the stories of Celestine and many others – this itinerary, though still uncharted, is clearly warranted. The margins of motherhood are not matters to be marginalized.

BIBLIOGRAPHY

Abega, S. C. (2007). *Les violences sexuelles et l'état au Cameroun*. Paris: Karthala.

Aboubakar, A. (2008). *Perceptions et pratiques des soins obstétricaux traditionnels chez les Pèrè de Gadjiwan (Prince de l'Adamaoua, Cameroun)*. Yaoundé: Université de Yaoundé I.

Abu-Lughod, L. (1993). *Writing women's worlds: Bedouin stories*. Berkeley: University of California Press.

Adams, A. (1995). Maternal bonds: recent literature on mothering. *Signs, 20*(2), 414-427.

Adetunji, J. A. (1996). Preserving the pot and water: a traditional concept of reproductive health in a Yoruba community, Nigeria. *Social Science & Medicine, 43*(11), 1561-1576.

Adome, R. O., Whyte, S. R., & Hardon, A. (1996). *Popular pills: community drug use in Uganda*. Amsterdam: Het Spinhuis.

African Union. (2003). *Protocol to the African charter on human and peoples' rights on the rights of women in Africa*. Maputo: African Union.

Ako, S., Fokoua, S., Sinou, M. T., & Leke, R. (2003). Reproductive health in Cameroon [Electronic Version]. Retrieved 03-03-2007, from http://www.gfmer.ch/Endo/Reprod_health/Cameroon/Net_Reproduction_Cameroun.htm.

Akuri, J., Weinger, S., & Barton, B. (2009). When personal dreams derail, rural Cameroonian women aspire for their children. *Journal of International Women's Studies, 11*(2), 142-156.

Alber, E. (2003). Denying biological parenthood: fosterage in northern Benin. *Ethnos, 68*(4), 487-506.

Allen, D. R. (2002). *Managing motherhood, managing risk: fertility and danger in West Central Tanzania*. Ann Arbor: University of Michigan Press.

Ardener, E. (1962). *Divorce and fertility, an African study*. London: Oxford University Press.

Ardener, S. G. (1973). Sexual insult and female militancy. *Man, 8*(3), 422-440.

Arreyanhyoh, M. T. A. (2007). *Enema and pregnancy from conception to childbirth: case study of Manyu community (South-West Province, Cameroon)*. Yaoundé: Université de Yaoundé I.

Asowa-Omorodion, F. I. (1997). Women's perceptions of the complications of pregnancy and childbirth in two Esan communities, Edo state, Nigeria. *Social Science & Medicine, 44*(12), 1817-1824.

Atangana, S. (1998). Aperçu historique de la mise en oeuvre des soins de santé primaires au Cameroun. In Ministère de la Santé Publique Cameroun (Ed.), *La mise en oeuvre de la réorientation des soins de santé primaires au Cameroun*. Yaoundé: Ministère de la Santé Publique.

Auerbach, J. D., & Figert, A. E. (1995). Women's health research: public policy and sociology. *Journal of Health and Social Behavior, 35*, 115-131.

Bahanag, A. M. B. (2003). *Politiques démographiques, traditions natalistes et développement durable au Cameroun*. Yaoundé: Université de Yaoundé I

Balla, C. (1991). *Parole et pouvoir chez les Beti (Cameroun Central). Approche ethnolinguistique*. Yaoundé: Université de Yaoundé I.

Bansen, S. S., & Stevens, H. A. (1992). Women's experiences of miscarriage in early pregnancy. *Journal of nurse-midwifery, 37*(2), 84-90.

Barbier, J.-C. (1985). *Femmes du Cameroun: mères pacifiques, femmes rebelles*. Paris: Karthala.

Barrere, B. (2005). Mortalité adulte et mortalité maternelle. In *Enquete Démographique et de Santé 2004*. Calverton, Maryland: ORC Macro.

Barth, F. (1975). *Ritual and knowledge among the Baktaman of New Guinea*. Oslo: Universitetsforlaget.

Barzelatto, J. (2004). *Catholics on abortion*. Washington, DC: Catholics for a Free Choice.

Basu, A. M. (2002). Why does education lead to lower fertility? A critical review of some of the possibilities. *World Development, 30*(10), 1779-1790.

Bauvineau, L. (2004). *Histoire de l'église Catholique dans l'Est du Cameroun*. Czestochowa: Educator.

Becker, G. (1994). Metaphors in disrupted lives: infertility and cultural constructions of continuity. *Medical Anthropology Quarterly, 8*(4), 383-410.

Becker, H. S. (1994). "Foi por Acaso": conceptualizing coincidence. *The Sociological Quarterly, 35*(2), 183-194.

Beninguissé, G. (2003). *Entre tradition et modernité: fondements sociaux de la prise en charge de la grossesse et de l'accouchement au Cameroun*. Louvain-la-Neuve: Bruylant-Academia.

Beninguissé, G. (2005). *Les politiques de santé de la reproduction en Afrique depuis la conférence du Caire: quelles implications pour la régulation de la fécondité?* Paper presented at the La regulation de la fécondité en Afrique. Transformations et differenciations au tournant du XXIe siècle.

Betbout, H., Ngueyap, F., Mudubu, K. L., & Rakotondrabe, P. (2000). *Santé de la reproduction au Cameroun: situation dans les formations sanitaires.* Yaoundé: IFORD.

Biehl, J. G., Good, B., & Kleinman, A. (2007). *Subjectivity: ethnographic investigations*. Berkeley: University of California Press.

Billard, P. (1961). *La circulation dans le Sud Cameroun*. Lyon: Impression des Beaux-Arts.

Bledsoe, C. (2002). *Contingent lives: fertility, time, and aging in West Africa*. Chicago, IL: University of Chicago Press.

Bledsoe, C., Banja, F., & Hill, A. G. (1998). Reproductive mishaps and Western contraception: an African challenge to fertility theory. *Population and Development Review, 24*(1), 15-58.

Bledsoe, C., Casterline, J. B., Johnson-Kuhn, J. A., & Haaga, J. G. (1999). *Critical perspectives on schooling and fertility in the developing world*. Washington: National Academy Press.

Bledsoe, C., & Cohen, B. (1993). *Social dynamics of adolescent fertility in Sub-Saharan Africa*. Washington: National Academy Press.

Bledsoe, C., Lerner, S., & Guyer, J. I. (2000). *Fertility and the male life cycle in the era of fertility decline*. Oxford: Oxford University Press.

Bledsoe, C., & Scherrer, R. F. (2007). The dialectics of disruption: paradoxes of nature and professionalism in contemporary American childbearing. In M. C. Inhorn (Ed.), *Reproductive disruptions: gender, technology, and biopolitics in the new Millennium* (pp. 47-78). New York: Berghahn Books.

Bleek, W. (1976). *Sexual relationships and birthcontrol in Ghana. A case study of a rural town.* Amsterdam: University of Amsterdam.

Bleek, W. (1981). Avoiding shame: the ethical context of abortion in Ghana. *Anthropological Quarterly, 54*(4), 203-209.

Bokally, M. (2003). *Contribution à l'étude des arts du corps chez les Fang au Sud du Cameroun, du 19e siècle à nos jours*. Yaoundé: Université de Yaoundé I.

Bongoe, A. (2007). Formation des personnels des formations sanitaires Catholiques de la province ecclesiastique de Bertoua, en santé de la reproduction, du 15 octobre au 10 novembre 2007. Rapport technique.

Bonnet, D. (1988). *Corps biologique, corps social: procréation et maladies de l'enfant en pays mossi, Burkina Faso*. Paris: ORSTOM.

Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge: Cambridge University Press.

Bourdieu, P. (1989). Social space and symbolic power. *Sociological Theory, 7*(1), 14-25.

Bourdieu, P. (2001). *Masculine domination*. Cambridge: Polity Press.

Bourne, S. (1968). The psychological effects of stillbirths on women and their doctors. *Journal of the Royal College of General Practitioners, 16*(2), 103-112.

Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss: sadness and depression*. New York: Basic Books.

Boyd Ritsher, J., & Neugebauer, R. (2002). Perinatal Bereavement Grief Scale: distinguishing grief from depression following miscarriage. *Assessment, 9*(1), 31-40.

Brand, S. M. A. A. (2001). *Mediating means and fate: a socio-political analysis of fertility and demographic change in Bamako, Mali*. Boston: Brill.

Brier, N. (1999). Understanding and managing the emotional reactions to a miscarriage. *Obstetrics and Gynecology, 93*(1), 151-155.

Brigham, S. A., Conlon, C., & Farquharson, R. G. (1999). A longitudinal study of pregnancy outcome following idiopathic recurrent miscarriage. *Human Reproduction, 14*, 2868-2871.

Bulatao, R. A., & Fawcett, J. T. (1983). *Influences on childbearing intentions across the fertility career: demographic and socioeconomic factors and the value of children*. Honolulu: East-West Center.

Buse, K., Drager, N., Fustukian, S., & Lee, K. (2002). Globalisation and health policy: trends and opportunities. In K. Lee, K. Buse & S. Fustukian (Eds.), *Health policy in a globalising world* (pp. 251-280). Cambridge: Cambridge University Press.

Calvès, A. E. (1999). Marginalization of African single mothers in the marriage market: evidence from Cameroon. *Population Studies, 53*(3), 291-301.

Calvès, A. E. (2000). Premarital childbearing in urban Cameroon: paternal recognition, child care and financial support. *Journal of Comparative Family Studies, 31*(4), 443-461.

Calvès, A. E. (2002). Abortion risk and decisionmaking among young people in urban Cameroon. *Studies in Family Planning, 33*(3), 249-260.

Calvès, A. E. (2004). *Décision d'avorter et déterminants des avortements clandestins chez les jeunes de Yaoundé*. Paper presented at the 'Santé de la reproduction au Nord et au Sud: de la connaissance à l'action'.

Calvès, A. E., & Meekers, D. (1997). The advantages of having many children for women in formal and informal unions in Cameroon. *CEPED series, 3*, 617-639.

Canguilhem, G. (1991). *On the normal and the pathological*. Dordrecht: Reidel.

Carey, M. A. (1994). The group effect in focus groups: planning, implementating, and interpreting focus group research. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 225-241). New York: Sage Publications.

Carsten, J. (2000). *Cultures of relatedness: new approaches to the study of kinship*. Cambridge: Cambridge University Press.

Carsten, J. (2004). *After kinship*. Cambridge: Cambridge University Press.

Carter, A. T. (1995). Agency and fertility: for an ethnography of practice. In S. Greenhalgh (Ed.), *Situating fertility: anthropology and demographic inquiry*. Cambridge: Cambridge University Press.

Casper, M. J. (1998). *The making of the unborn patient. A social anatomy of fetal surgery*. New Brunswick: Rutgers University Press.

Cates, W., Farley, T. M. M., & Rowe, P. J. (1985). Worldwide patterns of infertility: is Africa different? *The Lancet, 14*, 596-598.

Cecil, R. (Ed.). (1996). *The anthropology of pregnancy loss: comparative studies in miscarriage, stillbirth, and neonatal death*. Oxford: Berg Publishers.

CEDAW (1999). *Consideration of reports submitted by states parties under article 18 of the convention on the elimination of all forms of discrimination against women. Cameroon.*

CEPED (2000). Loi sur l'avortement. *La chronique du Ceped, 37*, 1-8.

Chapman, R. R. (2003). Endangering safe motherhood in Mozambique: prenatal care as pregnancy risk. *Social Science & Medicine, 57*(2), 355-374.

Chodorow, N. (1978). *The reproduction of mothering*. Berkeley: University of California Press.

Clifford, K., Rai, R., & Regan, L. (1997). Future pregnancy outcome in unexplained recurrent first trimester miscarriage. *Human Reproduction, 12*, 387-389.

Comaroff, J. L., & Roberts, S. (1981). *Rules and processes*. Chicago: University of Chicago Press.

Commission Nationale de la Population Cameroun (1993). *National Population Policy Declaration*. Yaoundé: Commission Nationale de la Population Cameroun.

Connell, P. (1997). Understanding victimization and agency: considerations of race, class and gender. *Political and Legal Anthropology Review, 20*(2), 115-143.

Conway, K., & Russell, G. (2000). Couples' grief and experience of support in the aftermath of miscarriage. *The British Journal of Medical Psychology, 73*, 531-545.

Copet-Rougier, E. (1985). Controle masculin, exclusivité féminine dans une société patrilinéaire. In J.-C. Barbier (Ed.), *Femmes du Cameroun. Mères pacifiques, femmes rebelles* (pp. 153-180). Paris: Karthala.

Copet-Rougier, E. (1987). Du clan à la chefferie dans l'Est du Cameroun. *Africa, 57*, 345-363.

Corbett, M. R., & Turner, K. L. (2003). Essential elements of postabortion care: origins, evolution and future directions. *International Family Planning Perspectives, 29*, 106-111.

Cornwall, A. (2007a). Of choice, chance and contingency: 'career strategies' and tactics for survival among Yoruba women traders. *Social Anthropology, 15*(1), 27-46.

Cornwall, A. (2007b). Taking chances, making choices: the tactical dimensions of "reproductive strategies" in Southwestern Nigeria. *Medical Anthropology, 26*(3), 229-254.

Criaud, J. (1990). *La geste des Spiritains. Histoire de l'Église au Cameroun*. Yaoundé: Publications du centenaire.

Csordas, T. J. (1990). Embodiment as a paradigm for anthropology. *Ethos, 18*(1), 5-47.

Csordas, T. J. (1994). *Embodiment and experience: the existential ground of culture and self*. Cambridge: Cambridge University Press.

Cuisinier, M. C. J., Graauw, C., Kuijpers, J. C., Hoogduin, C. A. L., & Minnen, A. (1992). Meting van rouw na een zwangerschapsverlies. Eerste bevindingen met de Nederlandse versie van de Perinatal Grief Scale (PGS). *Tijdschrift voor Psychiatrie, 34*(9), 651-656.

Curtis, C. (2007). Meeting health care needs of women experiencing complications of miscarriage and unsafe Abortion: USAID's postabortion care program. *Journal of Midwifery and Women's Health, 52*(4), 368-375.

David, N., & Voas, D. (1981). Societal causes of infertility and population decline among the settled Fulani of North Cameroon. *Man, 16*(4), 644-664.

de Certeau, M. (1984). *The practice of everyday life*. Berkeley: University of California Press.

de Lesdain, S. B. (1998). Sexualité et procréation chez les Mvae (Cameroun). *Autrepart, 7*, 139-152.

de Rosny, É. (1974). *Ndimsi: ceux qui soignent dans la nuit*. Yaoundé: Editions CLE.

de Thé, M. P. (1970). *Des sociétés secrètes aux associations modernes. La femme dans la dynamique de la société Beti, 1887-1966*. Paris: Ecole Pratique des Hautes Études.

Délégation Provinciale de la Santé de l'Est (1989). *Centres de santé dans la province de l'Est. Possibilités d'intégration dans les soins de santé primaires.* Bertoua: Ministère de la Santé Publique.

Délégation Provinciale de la Santé de l'Est (1999). *Carte sanitaire de la province de l'Est. Analyse au niveau provincial des fiches signalétiques*. Bertoua: Ministère de la Santé Publique.

Delpech, B. (1985). Femmes éton devant les tribunaux coutumiers. In J.-C. Barbier (Ed.), *Femmes du Cameroun. Meres pacifiques, femmes rebelles* (pp. 327-340). Paris: Karthala.

Devisch, R. (1993). *Weaving the threads of life: the khita gyn-eco-logical healing cult among the Yaka*. Chicago: University of Chicago Press.

Douglas, M. (1966). *Purity and danger: an analysis of concept of pollution and taboo*. London: Routledge.

Downe, S., & Dykes, F. (2009). Counting time in pregnancy and labour. In C. McCourt (Ed.), *Childbirth, midwifery and concepts of time* (pp. 61-83). New York: Berghahn books.

Duden, B. (1993). *Disembodying women: perspectives on pregnancy and the unborn*. Harvard: Harvard University Press.

Dugast, I. (1949). *Inventaire ethnique du Sud-Cameroun*. Douala: Institut français d'Afrique noire.

Dunkle, K. L., Jewkes, R., Nduna, M., Jama, N., Levin, J., Sikweyiya, Y., et al. (2007). Transactional sex with casual and main partners among young South African men in the rural Eastern Cape: prevalence, predictors, and associations with gender-based violence. *Social Science & Medicine, 65*(6), 1235-1248.

Dykes, F. (2009). 'Feeding all the time': women's temporal dilemmas around breastfeeding in hospital. In C. McCourt (Ed.), *Childbirth, Midwifery and Concepts of Time* (pp. 202-221). New York: Berghahn books.

Earle, S. (2004). 'Planned' and 'unplanned' pregnancy: deconstructing experiences of conception. *Human Fertility, 17*(1), 39–42.

Earle, S., Foley, P., Komaromy, C., & Lloyd, C. (2008). Conceptualizing reproductive loss: a social sciences perspective. *Human Fertility, 11*(4), 259-262.

Earle, S., & Letherby, G. (2002). Whose choice is it anyway? Decision making, control and conception. *Human Fertility, 5*(2), 39-41.

Earle, S., & Letherby, G. (2007). Conceiving time?: women who do or do not conceive. *Sociology of Health and Illness, 29*(2), 233–250.

Ebokea, M. F. (1994). *Femmes fragmentées*. Paris: Editions L'Harmattan.

Ehrlich, P. R. (1968). *The population bomb*. New York: Ballantine Books.

Ehrlich, P. R., & Ehrlich, A. H. (1990). *The population explosion*. New York: Simon and Schuster.

Einarsdóttir, J. (2000). *"Tired of weeping": child death and mourning among Papel mothers in Guinea-Bissau*. Stockholm: Almqvist & Wiksell.

Einarsdóttir, J. (2006). Relocation of children: fosterage and child death in Biombo, Guinea-Bissau. In C. Christiansen, M. Utas & H. Vigh (Eds.), *Navigating youth, generating adulthood: social becoming in an African context* (pp. 183-200). Uppsala: Nordiska Afrikainstitutet.

Einarsdóttir, J. (2009). Emotional experts: parents' views on end-of-life decisions for preterm infants in Iceland. *Medical Anthropology Quarterly, 23*(1), 34-50.

Eloundou-Enyegue, P. M. (2004). Pregnancy-related dropouts and gender inequality in education: a life-table approach and application to Cameroon. *Demography, 41*(3), 509-528.

Eloundou-Enyegue, P. M., Ngoube, M., Okene, R., Onguene, V., Bahoken, S., Tamukong, T., et al. (2004). Access to schooling and employment in Cameroon: new inequalities and opportunities. *Strategies and Analysis for Growth and Access (SAGA)*.

Eloundou-Enyegue, P. M., & Stokes, C. S. (2009). Will economic crises in Africa weaken rural-urban ties? Insights from child fosterage trends in Cameroon. *Rural Sociology, 67*(2), 278-298.

Eloundou-Enyegue, P. M., Stokes, C. S., & Cornwell, G. T. (2000). Are there crisis-led fertility declines? Evidence from central Cameroon. *Population Research and Policy Review, 19*(1), 47-72.

Ericksen, K., & Brunette, T. (1996). Patterns and predictors of infertility among African women: a cross-national survey of twenty-seven nations. *Social Science & Medicine, 42*(2), 209-220.

Erny, P. (1988). *Les premiers pas dans la vie de l'enfant d'Afrique Noire: naissance et première enfance*. Paris: L'Harmattan.

Erviti, J., Castro, R., & Collado, A. (2004). Strategies used by low-income Mexican women to deal with miscarriage and spontaneous abortion. *Qualitative Health Research, 14*(8), 1058-1076.

Eschlimann, J. P. (1982). *Naître sur la terre Africaine*. Abidjan: Inades.

Essoh, B. (1991). *Nuptialité à Bertoua*. Yaoundé: IFORD.

Eto, G. S. (2005). *Genre et recours thérapeutique au Cameroun*. Yaoundé: IFORD.

Evina Mbo, F. I. (2005). *Les facteurs explicatifs du multipartenariat sexuel au Cameroun*. Yaoundé: IFORD.

Featherstone, M., & Hepworth, M. (1991). *The body: social process and cultural theory*. London: Sage Publications Ltd.

Feldman-Savelsberg, P. (1996). Cooking inside: kinship and gender in Bangangté idioms of marriage and procreation. In M. J. Maynes (Ed.), *Gender, kinship, power: A comparative and interdisciplinary history* (pp. 176-197). New York: Routledge.

Feldman-Savelsberg, P. (1999). *Plundered kitchens, empty wombs: threatened reproduction and identity in the Cameroon grassfields*. Ann Arbor: University of Michigan Press.

Feldman-Savelsberg, P. (2002). Is Infertility an unrecognized public health and population problem? In M. C. Inhorn & F. v. Balen (Eds.), *Infertility around the globe: new thinking on childlessness, gender, and reproductive technologies* (pp. 215-232). Berkeley: University of California Press.

Feldman-Savelsberg, P., Ndonko, F., & Yang, S. (2006). The social management of fetal and infant death: dual disruptions to reproductive lives and discourses. *Curare, 29*(1), 17-26.

Feldman-Savelsberg, P., Schuster, S., & Ndonko, F. (2008). *Common but never routine: a differentiated view of illegal abortion in Cameroon*. Paper presented at the Reproductive Health Challenges: Multidisciplinary Approaches to Enhance Global Equity.

Fischer-Rosenthal, W. (2000). Biographical work and biographical structuring in present-day societies. In P. Chamberlayne, J. Bornat & T. Wengraf (Eds.), *The turn to biographical methods in social science: comparative issues and examples* (pp. 109-125). London: Routledge.

Fischer, J. M. (2003). Abortion, autonomy, and control over one's body. *Social Philosophy and Policy, 20*(2), 286-306.

Fischer, W., & Goblirsch, M. (2007). Biographical structuring. Narrating and reconstructing the self in research and professional practice. In M. G. W. Bamberg (Ed.), *Narrative: state of the art* (pp. 37-46). Amsterdam: John Benjamins Publishing Company.

Fisiy, C. F., & Geschiere, P. (1990). Judges and witches, or how is the state to deal with witchcraft? Examples from Southeast Cameroon. *Cahiers d'Etudes Africaines, 30*(118), 135-156.

Fisiy, C. F., & Geschiere, P. (1993). Sorcellerie et accumulation, variations régionales. In P. Geschiere & P. Konings (Eds.), *Itinéraires d'accumulation au Cameroun* (pp. 99-129). Paris: Karthala.

Folkman, S., Lazarus, R. S., Gruen, R. J., & DeLongis, A. (1986). Appraisal, coping, health status, and psychological symptoms. *Journal of Personality and Social Psychology, 50*(3), 571-579.

Ford, C. S. (1945). *A comparative study of human reproduction*. London: Oxford University Press.

Foster, G. M., & Anderson, B. G. (1978). *Medical anthropology*. New York: Wiley.

Foucault, M. (1994). *The order of things: an archaeology of the human sciences*. New York: Vintage Books.

Fouda, M. (2004). *Je parle Camerounais: pour un renouveau francofaune*. Paris: Karthala.

Frank, O. (1983). Infertility in sub-Saharan Africa: estimates and implications. *Population and Development Review, 9*(1), 137-144.

Franklin, S., & McKinnon, S. (2000). New directions in kinship study: a core concept revisited. *Current Anthropology, 41*(2), 275-279.

Frost, M., & Condon, J. T. (1996). The psychological sequelae of miscarriage: a critical review of the literature. *Australian and New Zealand journal of psychiatry, 30*(1), 54-62.

Fru, A. E. (2008). *Traditional birth attendants and maternal delivery in the Mbatu community (North West Province, Cameroon)*. Yaoundé: Université de Yaoundé I.

Gaïbaï, D. (2009). Mayo-Danay: 7.000 enfants sans acte de naissance. In *Mutations, March 31*.

Gammeltoft, T. (2006). 'Beyond being': emergent narratives of suffering in Vietnam. *Royal Anthropological Institute, 12*(3), 589-605.

Garenne, M. (2004). Age at marriage and modernisation in sub-Saharan Africa. *Southern African Journal of Demography, 9*(2), 59-79.

Gerber-Epstein, P., Leichtentritt, R., & Benyamini, Y. (2009). The experience of miscarriage in first pregnancy: the women's voices. *Death Studies, 33*(1), 1-29.

Gerrits, G. J. E. (1997). Social and cultural aspects of infertility in Mozambique. *Patient Education and Counseling, 31*(1), 39-48.

Gerrits, G. J. E. (2002). Infertility and matrilineality. In M. C. Inhorn & F. Van Balen (Eds.), *Infertility around the globe. New thinking on childlessness, gender, and reproductive technologies* (pp. 233-246). Berkeley: University of California Press.

Gerrits, G. J. E. (2008). *Clinical encounters: dynamics of patient-centred practices in a Dutch fertility clinic*. Amsterdam: University of Amsterdam.

Geschiere, P. (1982). *Village communities and the state: changing relations among the Maka of south-eastern Cameroon since the colonial conquest*. London; Boston: Kegan Paul International.

Geschiere, P. (1985). La visite des belles-mères chez les Maka. Une rébellion contre les hommes? In J.-C. Barbier (Ed.), *Femmes du Cameroun. Mères pacifiques, femmes rebelles* (pp. 194-216). Paris: Karthala.

Geschiere, P. (1997a). Kinship, witchcraft and the market. In R. R. Grinker & C. B. Steiner (Eds.), *Perspectives on Africa: a reader in culture, history, and representation* (pp. 340-358). Oxford: Blackwell Publishers.

Geschiere, P. (1997b). *The modernity of witchcraft: politics and the occult in postcolonial Africa*. London: University of Virginia Press.

Geschiere, P. (2003). Witchcraft as the dark side of kinship: dilemmas of social security in new contexts. *Etnofoor, 16*, 43-61.

Geschiere, P., & Fisiy, C. (1994). Domesticating personal violence: witchcraft, courts and confessions in Cameroon. *Africa: Journal of the International African Institute, 64*(3), 323-341.

Geschiere, P., & Konings, P. (1993). *Itinéraires d'accumulation au Caméroun = Pathways to accumulation in Cameroon*. Leiden: Afrika Studie Centrum.

Giddens, A. (1986). Action, subjectivity, and the constitution of meaning. *Social Research, 53*(3), 529-545.

Gilligan, C. (1982). *In a different voice: psychological theory and women's development*. Harvard: Harvard University Press.

Ginsburg, F. D., & Rapp, R. (1991). The politics of reproduction. *Annual Review of Anthropology, 20*, 311-343.

Ginsburg, F. D., & Rapp, R. (1995). *Conceiving the new world order: the global politics of reproduction*. Berkeley: University of California Press.

Godelier, M. (1992). Corps, parenté, pouvoir(s) chez les Baruya de Nouvelle-Guinée. *Journal de la Société des Océanistes, 94*(1), 3-24.

Goheen, M. (1993). Les champs appartiennent aux hommes, les récoltes aux femmes: accumulation dans la region de Nso. In P. Geschiere & P. Konings (Eds.), *Itinéraires d'accumulation au Cameroun* (pp. 241-272). Paris: Karthala.

Goheen, M. (1996). *Men own the fields, women own the crops. Gender and power in the Cameroon grassfields*. Madison: The University of Wisconsin Press.

Goody, E. (1984). Parental stragies: calculation or sentiment? Fostering practices among west africans. In H. Medick & D. W. Sabean (Eds.), *Interest and emotion: essays on the study of family and kinship* (pp. 9-27). Cambridge: Cambridge University Press.

Gottlieb, A. (2004). *The afterlife is where we come from: the culture of infancy in West Africa*. Chicago: University of Chicago Press.

Green, J., & Thorogood, N. (1998). *Analysing health policy: sociological approaches*. London: Addison Wesley Longman.

Greenhalgh, S. (1995). *Situating fertility: anthropology and demographic inquiry*. Cambridge: Cambridge University Press.

Grimes, B. F. (1988). Cameroon. In *Ethnologue* (pp. 162-189). Dallas: Summer Institute of Languages.

Grotevant, H. D. (2007). Openness in adoption: rethinking 'family' in the US. In M. C. Inhorn (Ed.), *Reproductive disruptions: gender, technology, and biopolitics in the new millennium* (pp. 122-144). New York: Berghahn Books.

Gruenais, M. E. (2001). Un système de santé en mutation: le cas du Cameroun. *Autrepart*, 1-6.

GTZ (2009). *Rape and incest in Cameroon. Final Report*. Yaoundé: GTZ.

Gubry, P., & Wautelet, J.-M. (1993). Population et processus de développement au Cameroun. *Intégrer Population et Développement*, 614-667.

Gupta, A. (2002). Reliving childhood? The temporality of childhood and narratives of reincarnation. *Ethnos: Journal of Anthropology, 67*(1), 33-55.

Guthrie, M. (1953). *The Bantu languages of western equatorial Africa*. London: Oxford University Press.

Guttmacher Institute (2003). Although abortion is highly restricted in Cameroon, it is not uncommon among young urban women. *International Family Planning Perspectives, 29*(1), 2-4.

Guy, D. J. (1993). Review: Death without weeping. *Contemporary Sociology, 22*(3), 351-352.

Guyer, J. I. (1984). *Family and farm in southern Cameroon* (Vol. 15). Boston: Boston University, African Studies Center.

Guyer, J. I. (1986). Indigenous currencies and the history of marriage payments: a case study from Cameroon. *Cahiers d'Études Africaines, 26*(104), 577-610.

Guyer, J. I. (1996). Traditions of invention in equatorial Africa. *African Studies Review, 39*(3), 1-28.

Guyer, J. I. (2005). Comment on "When the future decides: uncertainty and intentional action in contemporary cameroon" by Jennifer Johnson-Hanks. *Current Anthropology, 46*(3), 379.

Hahn, R. A., & Inhorn, M. C. (2009). *Anthropology and public health: bridging differences in culture and society*. New York: Oxford University Press.

Halliburton, M. (2002). Rethinking anthropological studies of the body: manas and bodham in Kerala. *American Anthropologist, 104*(4), 1123-1134.

Hanigsberg, J. E. (1995). Homologizing pregnancy and motherhood: a consideration of abortion. *Michigan Law Review, 94*(2), 371-418.

Hann, C. (2008). Reproduction and inheritance: Goody revisited. *Annual Review of Anthropology, 37*, 145-176.

Hardacre, H. (1999). *Marketing the menacing fetus in Japan*. Berkeley: University of California Press.

Hardin, G. (1974). Lifeboat ethics: the case against helping the poor. *BioScience, 24*(10), 561-568.

Hardon, A. P. (1987). The use of modern pharmaceuticals in a Filipino village: doctors' prescription and self medication. *Social Science & Medicine, 25*(3), 277-292.

Haws, R. A., Mashasi, I., Mrisho, M., Schellenberg, J. A., Darmstadt, G. L., & Winch, P. J. (2010). "These are not good things for other people to know": how rural Tanzanian women's experiences of pregnancy loss and early neonatal death may impact survey data quality. *Social Science & Medicine, 71*(10), 1764-1772.

Henshaw, S. K., Singh, S., & Haas, T. (1999). Recent trends in abortion rates worldwide. *International Family Planning Perspectives, 25*(1), 44-48.

Heriot, M. J. (1996). Fetal rights versus the female body: contested domains. *Medical Anthropology Quarterly, 10*(2), 176-194.

Héritier, F. (1984). Stérilité, aridité, sécheresse: quelques invariants de la pensée symbolique. In M. Augé & C. Herzlich (Eds.), *Le sens du mal. Anthropologie, histoire, sociologie de la maladie* (pp. 123-154). Paris: Editions des Archives Contemporaines.

Héritier, F. (2003). Une anthropologie symbolique du corps. *Journal des Africanistes, 73*(2), 9-26.

Hewson, B. (2001). Reproductive autonomy and the ethics of abortion. *Journal of Medical Ethics, 27*, 10-14.

Holtedahl, L. (1993). Education, economics and 'the good life': women in Ngaoundéré, Northern Cameroon. In P. Geschiere & P. Konings (Eds.), *Itinéraires d'accumulation au Cameroun* (pp. 273-300). Paris: Karthala.

Holy, L. (1996). *Anthropological perspectives on kinship*. London: Pluto Press.

Hours, B. (1985). *L'état sorcier: santé publique et société au Cameroun*. Paris: L'Harmattan.

Houseman, M. (1988). Social structure is where the hearth is: a "woman's place" in Beti society. *Africa, 58*(1), 51-69.

Hrdy, S. B. (1999). *Mother nature: a history of mothers, infants, and natural selection*. New York: Pantheon Books.

Hubbard, R. (1994). The politics of fetal-maternal conflict. In G. Sen & R. Snow (Eds.), *Power and decision: the social control of reproduction*. Boston: Harvard University Press.

Hunt, N. R. (2005). Fertility's fires and empty wombs in recent Africanist writing. *Africa, 75*(3), 421-435.

Hunter, M. (2002). The materiality of everyday sex: thinking beyond 'prostitution'. *African Studies, 61*(1), 99-120.

IMF (2006). *Cameroon: enhanced heavily indebted poor countries (HIPC) initiative. Completion point document and multilateral debt relief initiative (MDRI)*. Washington: IMF.

Inhorn, M. C. (1994). *Quest for conception: gender, infertility, and Egyptian medical traditions*. Philadelphia: University of Pennsylvania Press.

Inhorn, M. C. (1996). *Infertility and patriarchy: the cultural politics of gender and family life in Egypt*. Philadelphia: University of Philadelphia Press.

Inhorn, M. C. (2006). Defining women's health: a dozen messages from more than 150 ethnographies. *Medical Anthropology Quarterly, 20*(3), 345-378.

Inhorn, M. C., & Birenbaum-Carmeli, D. (2008). Assisted reproductive technologies and culture change. *Annual Review of Anthropology, 37*, 177-234.

Ivry, T. (2009). The ultrasonic picture show and the politics of threatened life. *Medical Anthropology Quarterly, 23*(3), 189-211.

Jackson, E. (2000). Abortion, autonomy and prenatal diagnosis. *Social & Legal Studies, 9*(4), 467-494.

Jackson, M. (1998). *Minima ethnographica: intersubjectivity and the anthropological project*. Chicago: University of Chicago Press.

Jackson, M., & Karp, I. (1990). *Personhood and agency: the experience of self and other in African cultures*. Uppsala: Acta Universitatis Upsaliensis.

Janes, C. R., & Corbett, K. K. (2009). Anthropology and global health. *Annual Review of Anthropology, 38*(1), 167-183.

Jeffery, P., & Jeffery, R. (1996). Delayed periods and falling babies: the ethnophysiology and politics of pregnancy loss in rural North India. In R. Cecil (Ed.), *The anthropology of pregnancy loss: comparative studies in miscarriage, stillbirth, and neonatal death* (pp. 17-38). Oxford: Berg.

Jeffery, P., & Jeffery, R. (2010). Only when the boat has started sinking: A maternal death in rural north India. *Social Science & Medicine, 71*(10), 1711-1718.

Jejeebhoy, S. J. (1995). *Women's education, autonomy, and reproductive behaviour: experience from developing countries*. Oxford: Oxford University Press.

Jenkins, G. L., & Inhorn, M. C. (2003). Reproduction gone awry: medical anthropological perspectives. *Social Science & Medicine 56*(9), 1831-1836.

Johnson-Hanks, J. (2002a). The lesser shame: abortion among educated women in southern Cameroon. *Social Science & Medicine, 55*(8), 1337-1349.

Johnson-Hanks, J. (2002b). On the limits of life stages in ethnography: toward a theory of vital conjunctures. *American Anthropologist, 104*(3), 865-880.

Johnson-Hanks, J. (2002c). On the modernity of traditional contraception: time and the social context of fertility. *Population and Development Review, 28*(2), 229-249.

Johnson-Hanks, J. (2005). When the future decides: uncertainty and intentional action in contemporary Cameroon. *Current Anthropology, 46*(3), 363-386.

Johnson-Hanks, J. (2006). *Uncertain honor: modern motherhood in an African crisis*. Chicago: The University of Chicago Press.

Johnson-Hanks, J. (2007). Women on the market: marriage, consumption, and the Internet in urban Cameroon. *American Ethnologist, 34*(4), 642-658.

Johnson, J. M., Thompson, S. L., & Perry, G. J. (1990). Juju-soup: the witch herbalist's solution for infertility. *African Studies Review, 33*(1), 55-64.

Jones, L. S. (2001). Hope deferred: theological reflections on reproductive loss (infertility, stillbirth, miscarriage). *Modern Theology, 17*(2), 227-245.

Jordan, B. (1978). *Birth in four cultures: a cross-cultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States*. London: Eden Press.

Kamdoum, A. (1994a). Les conditions de succès de la politique de population au Cameroun. In F. Gendreau, D. Nzita Kikhela & V. Guérin (Eds.), *L'évaluation des politiques et programmes de population* (pp. 111-119). Montrouge: J. Libbey Eurotext.

Kamdoum, A. (1994b). Planification sanitaire et ajustement structurel au Cameroun. *Dossiers du CEPED, 29*, 12-35.

Kamla, E. P. (1992). *Les groupes ethniques dans la formation de la nation. Le cas du Cameroun*. Rome: Tipografia Poliglotta della Pontificia Università Gregoriana.

Kamtcha, Y. M. M. (2004). *Pluralisme thérapeutique au Cameroun: contribution à la comprehension des conduits de recours multiples*. Yaoundé: IFORD.

Kandiyoti, D. (1988). Bargaining with patriarchy. *Gender and society, 2*(3), 274-290.

Kaufman, S. R., & Morgan, L. M. (2005). The anthropology of the beginnings and ends of life. *Annual Review of Anthropology, 34*, 317-362.

Kay, M. A. (1982). *Anthropology of human birth*. Philadelphia: F.A. Davis.

Kielmann, K. (1998). Barren ground: constesting identities of infertile women in Pemba, Tanzania. In M. Lock & P. A. Kaufert (Eds.), *Pragmatic women and body politics* (pp. 127-163). Cambridge: Cambridge University Press.

Kim, N. (1999). Breaking free from patriarchy: a comparative study of sex selection abortions in Korea and the United States. *UCLA Pacific Basin Law Journal, 17*, 301-326.

Kirmayer, L. J. (1992). The body's insistence on meaning: metaphor as presentation and representation in illness experience. *Medical Anthropology Quarterly, 6*(4), 323-346.

Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health and Illness, 16*(1), 103-121.

Klaus, M. H., & Kennel, J. (Eds.). (1976). *Maternal-infant bonding*. St.Louis: Mosby.

Kleiner-Bossaller, A. (1993). Kwantacce, the sleeping pregnancy, a hausa concept. In G. Ludwar-Ene & M. Reh (Eds.), *Focus on women in Africa* (pp. 17-29). Bayreuth: African Studies Series.

Kleinman, A., Das, V., & Lock, M. M. (1997). *Social suffering*. Berkeley: University of California Press.

Konings, P. (1995). Plantation labour and economic crisis in Cameroon. *Development and Change, 26*, 525-549.

Koster, W. (2003). *Secret strategies. Women and abortion in Yoruba society, Nigeria*. Amsterdam: Aksant.

Koster, W. (2010). Linking two opposites of pregnancy loss: induced abortion and infertility in Yoruba society, Nigeria. *Social Science & Medicine, 71*(10), 1788-1795.

Krumeich, J. S. M. (1994). *The blessings of motherhood. Health, pregnancy and child care in Dominica*. Amsterdam: Het Spinhuis.

Laburthe-Tolra, P. (1981). *Mínlaaba. Les seigneurs de la fôret*. Paris: Karthala.

Laburthe-Tolra, P. (1985). *Initiations et sociétés secrètes au Cameroun: les mystères de la nuit*. Paris: Karthala.

Laburthe-Tolra, P. (1999). *Vers la lumière? ou, Le désir d'Ariel: à propos des Beti du Cameroun. Sociologie de la conversion*. Paris: Karthala.

Laderman, C. (1987). *Wives and midwives: childbirth and nutrition in rural Malaysia*. Berkeley: University of California Press.

Lambert, H., & McDonald, M. (Eds.). (2009). *Social bodies*. New York: Berghahn books.

Lantum, D. N. (1976). *The sterility problem in Cameroon (a socio-demographic aspect)*. Paper presented at the WHO Task force on Infertiltiy.

Larsen, U. (1995). Differentials in infertility in Cameroon and Nigeria. *Population Studies, 49*(2), 329-346.

Layne, L. L. (1997). Breaking the silence: an agenda for a feminist discourse of pregnancy loss. *Feminist Studies, 23*(2), 289-316.

Layne, L. L. (2003). *Motherhood lost: a feminist account of pregnancy loss in America*. New York: Routledge.

Layne, L. L. (2006). A women's health model for pregnancy loss: a call for a new standard of care. *Feminist Studies, 32*(3), 573-600.

Leclerc-Madlala, S. (2003). Transactional sex and the pursuit of modernity. *Social Dynamics: A journal of African studies, 29*(2), 213-233.

Lee, B. S. (1992). The influence of rural-urban migration on migrant's fertility behavior in Cameroon. *International Migration Review, 26*(4), 1416-1447.

Lee, C., & Slade, P. (1996). Miscarriage as a traumatic event: a review of the literature and new implications for intervention. *Journal of Psychosomatic Research, 40*(3), 235-244.

Legba, J. Y. (1998). La synthèse de l'étude des cas de huit pays Africains sur la mise en oeuvre des reformes du secteur de santé. In Ministère de la Santé Publique Cameroun (Ed.), *La mise en oeuvre de la réorientation des soins de santé primaires au Cameroun*. Yaoundé: Ministère de Santé Publique.

Leh, J. G. (1987). *Les soins de santé primaires dans les pays du tiers monde. À propos d'une expérience personnelle chez les Banen du Cameroun de 1981 à 1984*. Yaoundé: Université de Yaoundé I.

Leonard, L. (2002). "Looking for children": the search for fertility among the Sara of Southern Chad. *Medical Anthropology Quarterly, 21*(1), 79-112.

Letherby, G. (1993). The meanings of miscarriage. *Women's Studies International Forum, 16*(2), 165-180.

Letherby, G. (1999). Other than mother and mothers as others: the experience of motherhood and non-motherhood in relation to 'infertility' and 'involuntary childlessness'. From 'inside/out' to 'outside/in'. *Womens Studies International Forum, 22*(3), 359-372.

Levine, N. E. (2008). Alternative kinship, marriage, and reproduction. *Annual Review of Anthropology, 37*, 375-389.

Libite, P. R. (2005a). Fécondité. In *Enquête Démographique et de Santé 2004*. Claverton, Maryland: OVC Macro.

Libite, P. R. (2005b). Mortalité des enfants. In *Enquête Démographique et de Santé 2004*. Claverton, Maryland: OVC Macro.

Liboko Ndabanga, S. L. (2001). *Facteurs explicatifs des comportements sexuels des femmes en Afrique Subsaharienne. Cas du Cameroun*. Yaoundé: IFORD.

Linger, D. T. (1993). Review: Death without weeping; State of siege on the hill of the cross. *American Ethnologist, 20*(4), 844-847.

LiPuma, E. (1998). Modernity and forms of personhood in Melanesia. In M. Lambek & A. Strathern (Eds.), *Bodies and persons: comparative perspectives from Africa and Melanesia* (pp. 53-79). Cambridge: Cambridge University Press.

Littlewood, J. (1999). From the invisibility of miscarriage to an attribution of life. *Anthropology & Medicine, 6*(2), 217-230.

Lloyd, C. B., & Mensch, B. S. (2008). Marriage and childbirth as factors in dropping out from school: an analysis of DHS data from sub-Saharan Africa. *Population Studies: A Journal of Demography, 62*(1), 1-13.

Lock, M. (1993a). Cultivating the body: anthropology and epistemologies of bodily practice and knowledge. *Annual Review of Anthropology, 22*, 133-155.

Lock, M. (1993b). *Encounters with aging: mythologies of menopause in Japan and North America*. Berkeley: University of California Press.

Lock, M., & Kaufert, P. A. (1997). *Pragmatic women and body politics*. New York: Cambridge University Press.

Lovell, A. (1983). Some questions of identity: late miscarriage, stillbirth and perinatal loss. *Social Science & Medicine, 17*(11), 755-761.

Lyon, M. L. (1997). The material body, social processes and emotion: 'techniques of the body' revisited. *Body & Society, 3*(1), 83-101.

MacCormack, C. P. (1982). *Ethnography of fertility and birth*. New York: Academic.

Mackenzie, C., & Stoljar, N. (2000). *Relational autonomy: feminist perspectives on automony, agency, and the social self*. New York: Oxford University Press.

Mahoney, M. (1994). Victimization or oppression? Women's lives, violence and agency. In M. A. Fineman & R. Mykitiuk (Eds.), *The public nature of private violence* (pp. 59-92). New York: Routledge.

Mallart Guimera, L. (1981). *Ni dos ni ventre: religion, magie et sorcellerie Evuzok*. Paris: Société d'Ethnographie.

Margolis, M. L. (1993). Review: Death without weeping. *American Anthropologist, 95*(2), 495-497.

Marris, P. (1974). *Loss and change*. New York: Pantheon.

Mauss, M. (1950). Les techniques du corps. In M. Mauss (Ed.), *Sociologie et anthropologie* (pp. 363-386). Paris: PUF.

Maynard, K. (2004). *Making Kedjom medicine: a history of public health and well-being in Cameroon*. Westport: Praeger.

Mbuy, R. S. (1990). *Family planning in Cameroon: the extent of the influence of social and cultural determinants on family size in a rural community. The case of Bui division*. Yaoundé: Université de Yaoundé I.

McClain, C. (1982). Toward a comparative framework for the study of childbirth: a review of the literature. In M. A. Kay (Ed.), *Anthropology of human birth* (pp. 25-59). Philadelphia: FA Davis.

Médard, J. F. (2001). Décentralisation du système de santé publique et ressources humaines au Cameroun [Electronic Version]. *Bulletin de l'APAD*, *21*, from http://apad.revues.org/document35.html.

Meekers, D., & Calvès, A. E. (1997). 'Main' girlfriends, girlfriends, marriage, and money: the social context of HIV risk behaviour in sub-Saharan Africa. *Health Transition Review, 7*, 361-375.

Meekers, D., & Klein, M. (2002a). Determinants of condom use among young people in urban Cameroon. *Studies in Family Planning, 33*(4), 335-346.

Meekers, D., & Klein, M. (2002b). Understanding gender differences in condom use self-efficacy among youth in urban Cameroon.

Mengue, A. (1982). *L'Est Camerounais. Une géographie du sous-peuplement et de la marginalité*. Bordeaux: Université de Bordeaux.

Meyers, D. T. (2001). The rush to motherhood: pronatalist discourse and women's autonomy. *Signs, 26*, 735-774.

MINEPAT (2008). *MICS 3. Enquête par grappes à indicateurs multiples. Suivi de la situation des enfants et des femmes*. Yaoundé: MINEPAT.

Ministère de la Santé Publique Cameroun (1993a). *Alimentation des enfants de 0 à 5 ans, femmes enceintes et allaitantes (connaissances, attitudes, croyances et pratiques). Est-Cameroun. Rapport final*.

Ministère de la Santé Publique Cameroun (1993b). *Alimentation des enfants de 0 à 5 ans, femmes enceintes et allaitantes dans les provinces de l'Extrème-Nord, Est, Ouest et dans la ville de Douala (revue de la littérature)*.

Ministère de la Santé Publique Cameroun (1993c). *Maternal and child health care and family planning service policies and standards*. Yaoundé: Ministère de la Santé Publique.

Ministère de la Santé Publique Cameroun (1993d). *National declaration on the implementation of the reorientation of primary health care*. Yaoundé: Ministère de la Santé Publique Cameroun.

Ministère de la Santé Publique Cameroun (1994). *Rapport de l'étude ethnographique dans la province de l'Est*.

Ministère de la Santé Publique Cameroun (1995). *Identification des problèmes nutritionnels des enfants de 0 à 5 ans, femmes enceintes et allaitantes à partir des données de la phase d'exploration. Est-Cameroun*.

Ministère de la Santé Publique Cameroun (1999). *Module de formation: réorientation des soins de santé primaires, participation communautaire, gestion d'un centre en recouvrement des couts*. Yaoundé: Ministère de la Santé Publique.

Ministère de la Santé Publique Cameroun (2001a). *Declaration of the national population policy*. Yaoundé: Ministère de la Santé Publique.

Ministère de la Santé Publique Cameroun (2001b). *Politique et normes des services de la santé de la reproduction*. Yaoundé: Ministère de la Santé Publique.

Ministère de la Santé Publique Cameroun (2006). *Plan stratégique national de lutte contre le VIH/SIDA 2006-2010*.

Ministère de la Santé Publique Cameroun (n.d.). *Module sur le recouvrement des couts. Draft no. 1*. Yaoundé: Ministère de la Santé Publique.

Mitchell, L. M. (2006). Body and illness: considering Visayan Filipino children's perspectives within local and global relationships of inequality. *Medical Anthropology, 25*(4), 331-373.

Molel Belika, L. (2008). *La notion de la personne chez les Banen du Cameroun*. Yaoundé: Université de Yaoundé I.

Monach, J. H. (1993). *Childless, no choice: the experience of involuntary childlessness*. New York: Routledge.

Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology, 22*, 129-152.

Morgan, L. M. (1996). Fetal relationality in feminist philosophy: an anthropological critique. *Hypatia, 11*(3), 47-70.

Mosoko, J. J., & Affana, G. A. N. (2005). Prévalence du VIH et facteurs associées. In *Enquête Démographique et de Santé 2004*. Claverton, Maryland: OVC Macro.

Moupou, M., & Akei Mbanga, L. (2008). Désengagement de l'État et réponses paysannes au Cameroun. *Les Cahiers d'Outre-Mer, 61*(241), 163-183.

Nahar, P. (2007). *Childless in Bangladesh: suffering and resilience among rural and urban women*. Amsterdam: University of Amsterdam.

Nana-Fabu, S. (2001). High fertility and development in Cameroon. *Journal of Social Development in Africa, 16*, 25-44.

Nasah, B. T. (1978). Aetiology of infertility in the Came Roune. *Nigerian Medical Journal, 8*(5), 452-456.

Nations, M. K., Misago, C., Fonseca, W., Correia, L. L., & Campbell, O. M. R. (1997). Women's hidden transcripts about abortion in Brazil. *Social Science & Medicine, 44*(12), 1833-1845.

Nelson, H. D., Dobert, M., McDonald, G. C., McLaughlin, J., Marvin, B., & Moeller, P. W. (1974). *Area handbook for the United Republic of Cameroon*. Washington: Foreign Area Studies.

Newman, L. F. (1985). *Women's medicine: a cross-cultural study of indigenous fertility regulation*. New Brunswick: Rutgers University Press.

Ng'weshemi, J. Z. L., Boerma, J., Pool, R., Barongo, L., Senkoro, K., Maswe, M., et al. (1996). Changes in male sexual behaviour in response to the AIDS epidemic: evidence from a cohort study in urban Tanzania. *Aids, 10*(12), 1415.

Ngo Baleba, A. (2003). *Ils ont construit l'Église de l'Est Cameroun 1900-2000: des Pères spiritains se racontent*. Czestochowa: Educator.

Ngo Bell, V. R. (1990). *Les familles Camerounaises face au planning familiale. Intégration ou rejet?* Yaoundé: Université de Yaoundé I.

Ngono, M. G. (2005). *Facteurs de la pratique de la prévention antivectorielle dans les ménages de l'Est Cameroun*. Yaoundé: Université de Yaoundé I.

Nguyen, T. H. (2011). *Rape experiences and the limits of women's agency in contemporary post-reform Vietnam*. Amsterdam: University of Amsterdam.

Nichter, M. (1981). Idioms of distress: alternatives in the expression of psychosocial distress. A case study from South India. *Culture, Medicine and Psychiatry, 5*(4), 379-408.

Niger-Thomas, M. (2000). *Buying futures. The upsurge of female entrepreneurship: crossing the rormal and informal divide in Southwest Cameroon*. Leiden: Leiden University.

Njikam Savage, O. M. (1992). Artificial donor insemination in Yaoundé: some socio-cultural considerations. *Social Science & Medicine, 35*, 297-306.

Njikam Savage, O. M. (1996). 'Children of the rope' and other aspects of pregnancy loss in Cameroon. In R. Cecil (Ed.), *The anthropology of pregnancy loss: comparative studies in miscarriage, stillbirth, and neonatal death* (pp. 95-107). Oxford: Berg.

Njikam Savage, O. M. (1998). Adolescents' beliefs and perceptions towards sexuality in urban Cameroon. In B. Kuate-Defo (Ed.), *Sexuality and reproductive health during adolescence in Africa, with special reference to Cameroon* (pp. 77-90). Ottawa: University of Ottawa.

Nkwi, P. (1985). Traditional female militancy in a modern context. In J.-C. Barbier (Ed.), *Femmes du Cameroun. Mères pacifiques, femmes rebelles* (pp. 181-191). Paris: Karthala.

Notermans, C. (1999). *Verhalen in veelvoud: vrouwen in Kameroen over polygynie en christendom*. Nijmegen: Valkhof Pers.

Notermans, C. (2003). Nomads in kinship: fosterage and the self in Cameroon. *Focaal* (42), 89-104.

Notermans, C. (2004). Sharing home, food, and bed: paths of grandmotherhood in East Cameroon. *Africa, 74*(1), 6-27.

Notermans, C. (2008). The emotional world of kinship: children's experiences of fosterage in East Cameroon. *Childhood: A Global Journal of Child Research, 15*(3), 355-377.

Nseke, M. M. (2002). *La planification familiale au Cameroun: les facteurs limitants*. Yaoundé: Université de Yaoundé I.

Nsoa Mbondo, P. (2008). *Besoins non satisfaits en matière d'éducation sur les complications obstétricales au Cameroun: niveaux et déterminants*. Yaoundé: IFORD.

Nyamnjoh, F. B. (2002). 'A child is one person's only in the womb'. Domestication, agency and subjectivity in the Cameroonian Grassfields. In R. Werbner (Ed.), *Postcolonial subjectivities in Africa* (pp. 111-138). London: Zed Books.

Nyamnjoh, F. B. (2005). Fishing in troubled waters: disquettes and thiofs in Dakar. *Africa, 75*(3), 295-324.

Nyanzi, S., Pool, R., & Kinsman, J. (2001). The negotiation of sexual relationships among school pupils in south-western Uganda. *AIDS care, 13*(1), 83-98.

Nyobia, A. (2006). Avortement clandestine: le business 'fertile'. In *Cameroon Tribune. Le Quotidien National Bilingue*.

O'Neill, J. (1985). *Five bodies: the human shape of modern society*. Ithaca: Cornell University Press.

Okalla, R., & Le Vigouroux, A. (2001). Cameroun: de la réorientation des soins de santé primaires au plan national de développement sanitaire [Electronic Version]. *Bulletin de l'APAD*, *21*, from http://apad.revues.org/document181.html.

Okonufua, F. E. (1994). Induced abortion: a risk factor for infertility in Nigerian women. *Journal of Obstetrics & Gynaecology, 14*(4), 272.

Olarte Sierre, M. F. (2010). *Achieving the desirable nation : abortion and antenatal testing in Colombia : the case of amniocentesis*. Amsterdam: University of Amsterdam.

Olivier de Sardan, J. P., Moumouni, A., & Souley, A. (2000). "L'accouchement c'est la guerre": accoucher en milieu rural nigérien. *Afrique Contemporaine, 195*, 136-154.

Ombolo, J. P. (1991). *Sexe et société en Afrique noire: l'anthropologie sexuelle Beti. Essai analytique, critique et comparatif*. Paris: L'Harmattan.

Onambele, M. J. (1995). *De l'origine et de la structure sociale des Ewondo*. Yaoundé: Université de Yaoundé I.

Ortner, S. B. (1996). *Making gender: the politics and erotics of culture*. Boston: Beacon Press.

Ortner, S. B. (2006). *Anthropology and social theory: culture, power, and the acting subject*. Durham: Duke University Press.

Owona Essomba, R., Bryant, M., & Bodart, C. (1993). The reorientation of primary health care in Cameroon: rationale, obstacles and constraints. *Health Policy and Planning, 8*(3), 232-239.

Oyono, F. (1967). *The old man and the medal*. London: Heinemann.

Paxson, H. (2004). *Making modern mothers: ethics and family planning in urban Greece*. Berkeley: University of California Press.

Petchesky, R. P. (1980). Reproductive freedom: beyond "a woman's right to choose". *Signs, 5*(4), 661-685.

Petchesky, R. P. (1987). Fetal images: the power of visual culture in the politics of reproduction. *Feminist Studies, 13*(2), 263-292.

Pfeiffer, J., & Nichter, M. (2008). What can critical medical anthropology contribute to global health? *Medical Anthropology Quarterly, 22*(4), 410-415.

Piot, C. D. (1993). Secrecy, ambiguity, and the everyday in Kabre culture. *American Anthropologist, 95*(2), 353-370.

Piot, C. D. (1999). *Remotely global: village modernity in West Africa*. Chicago: University of Chicago Press.

Pollack, S. (2000). Reconceptualizing women's agency and empowerment. *Women & Crimial Justice, 12*(1), 75-89.

Pool, R. (1994). On the creation and dissolution of ethnomedical systems in the medical ethnography of Africa. *Africa, 64*, 1-20.

Pool, R. (2003). *Dialogue and the interpretation of illness: conversations in a Cameroon village*. Amsterdam: Het Spinhuis.

Potter, R. G. (1975). Competition between spontaneous and induced abortion. *Demography, 12*(1), 129-141.

Potvin, L., Lasker, J., & Toedter, L. (1989). Measuring grief: a short version of the Perinatal Grief Scale. *Journal of Psychopathology and Behavioral Assessment, 11*(1), 29-45.

Poulin, M. (2007). Sex, money, and premarital partnerships in southern Malawi. *Social Science & Medicine, 65*(11), 2383-2393.

Puddifoot, J. E., & Johnson, M. P. (1997). The legitimacy of grieving: the partner's experience at miscarriage. *Social Science & Medicine, 45*(6), 837-845.

Radcliffe-Brown, A. R. (1940). On joking relationships. *Africa: Journal of the International African Institute, 13*(3), 195-210.

Rahman, A., Katzive, L., & Henshaw, S. K. (1998). A global review of laws on induced abortion, 1985-1997. *International Family Planning Perspectives, 24*(2), 56-64.

Rapp, R. (2000). *Testing women, testing the fetus: the social impact of amniocentesis in America*. New York: Routledge.

Reinharz, S. (1988). What's missing in miscarriage? *Journal of Community Psychology, 16*(1), 84-103.

Renne, E. P. (1996). The pregnancy that doesn't stay: the practice and perception of abortion by Ekiti Yoruba women. *Social Science & Medicine, 42*(4), 483-494.

Renne, E. P. (2003). Changing assessments of abortion in a northern Nigerian town. In A. M. Basu (Ed.), *The sociocultural and political aspects of abortion: global perspectives* (pp. 119-138). Westport, Connecticut: Praeger.

Renne, E. P. (2006). Abortion as illegal conduct and its sequelae in Nigeria. *Curare, 29*(1), 81-96.

Retel-Laurentin, A. (1974). *Infécondité en Afrique noire: maladies et conséquences sociales*. Paris: Masson.

Rice, P. L. (2000). When the baby falls!: the cultural construction of miscarriage among Hmong women in Australia. *Women & Health, 30*(1), 85-103.

Richards, S. C. (2002). "Spoiling the womb": definitions, aetiologies and responses to infertility in north west province, Cameroon. *African Journal of Reproductive Health, 6*(1), 84-94.

Romaniuk, A. (1961). *L'aspect démographique de la stérilité des femmes Congolaises*. Leopoldville: Editions de l'université.

Romaniuk, A. (1967). *La fecondité des populations congolaises*. Paris: Mouton.

Romaniuk, A. (1968). Infertility in tropical Africa. In J. C. Caldwell & C. Okonjo (Eds.), *The population of tropical Africa* (pp. 214-224). London: Longmans.

Rosenthal, G. (2003). The healing effects of storytelling: on the conditions of curative storytelling in the context of research and counseling. *Qualitative Inquiry, 9*(6), 915-933.

Rosenthal, G. (2004). Biographical research. In C. Seale, G. Gobo, J. F. Gubrium & D. Silverman (Eds.), *Qualitative research practice* (pp. 48-64). New York: Sage.

Rosenthal, G. (2006). The narrated life story: in the interrelation between experience, memory and narration. In G. Rosenthal (Ed.), *Narrative, memory, knowledge: representations, aesthetics, contexts* (pp. 1-16). Huddersfield: University of Huddersfield.

Ross, J. L., Laston, S. L., Nahar, K., Muna, L., Nahar, P., & Pelto, P. J. (1998). Women's health priorities: cultural perspectives on illness in rural Bangladesh. *Health, 2*(1), 91-110.

Ruddick, S. (1980). Maternal thinking. *Feminist Studies, 6*(2), 342-367.

Sala-Diakanda, D. (2000). La positions des gouvernements Africains vis-à-vis des politiques démographiques en matière de fécondité. In P. Vimard, B. C. Zanou & M. E. Z. de Cosio (Eds.), *Politiques démographiques et transition de la fécondité en Afrique* (pp. 13-45). Paris: L'Harmattan.

Sargent, C. F. (1982). *The cultural context of therapeutic choice: obstetrical care decisions among the Bariba of Benin*. Dordrecht: D. Reidel Publishing Company.

Sargent, C. F. (1989). *Maternity, medicine, and power: reproductive decisions in urban Benin*. Berkeley: University of California Press.

Scheper-Hughes, N. (1992). *Death without weeping: the violence of everyday life in Brazil*. Berkeley: University of California Press.

Scheper-Hughes, N., & Lock, M. M. (1987). The mindful body: a prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly, 1*(1), 6-41.

Schneider, E. M. (1993). Feminism and the false dichotomy of victimization and agency. *New York Law School Law Review, 38*, 387-399.

Schuster, S. (2005). Abortion in the moral world of the Cameroon Grassfields. *Reproductive Health Matters, 26*, 130-138.

Schuster, S. (2010). Women's experiences of the abortion law in Cameroon: "What really matters". *Reproductive Health Matters, 18*(35), 137-144.

Scott, J. C. (1990). *Domination and the arts of resistance. Hidden transcripts*. New Haven: Yale University Press.

SIL International (2001). Ethnologue: languages of the world [Electronic Version]. Retrieved 31-03-2005, from http://www.ethnologue.com/show_country.asp?name=Cameroon.

Slama, M. (2007). Review of Uncertain honor. Modern motherhood in an African crisis. *European Association of Social Anthropologists*, 393-394.

Sobo, E. J. (1996). Cultural explanations for pregnancy loss in Rural Jamaica. In R. Cecil (Ed.), *The anthropology of pregnancy loss: comparative studies in miscarriage, stillbirth, and neonatal death* (pp. 39-58). Oxford: Berg Publishers.

Sökefeld, M. (1999). Debating self, identity, and culture in anthropology. *Current Anthropology, 40*(4), 417-448.

Sous-préfecture de Bélabo (2007). *Procès-verbal de passation de commandement entre mm. Engamba Emmanuel Ledoux, sous-préfet sortant, et Embe David, sous-préfect entrant de l'arrondissement de Bélabo*. Bélabo: Sous-préfecture de Bélabo.

Spiro, M. E. (1993). Is the Western conception of the self "peculiar" within the context of the world cultures? *Ethos, 21*(2), 107-153.

Sporton, D. (1999). Mixing methods in fertility research. *The Professional Geographer, 51*(1), 68-76.

Spruit, L. G. M. (1991). *Religie en abortus. Interactiemodellen ter verklaring van de houding tegenover abortus* Nijmegen: KASKI.

Strathern, M. (1995). *The relation: issues in complexity and scale*. Cambridge: Prickly Pear.

Sundby, J., Mboge, R., & Sonko, S. (1998). Infertility in the Gambia: frequency and health care seeking. *Social Science & Medicine, 46*(7), 891-899.

Svanemyr, J., & Sundby, J. (2007). The social context of induced abortions among young couples in Cote d'Ivoire. *African Journal of Reproductive Health, 11*(2), 13-23.

Tantchou, J., & Wilson, E. (2000). *Post-Cairo reproductive health policies and programs: a study of five Francophone African countries* (Vol. 6). Washington: POLICY Project.

Tawfik, L., & Watkins, S. C. (2007). Sex in Geneva, sex in Lilongwe, and sex in Balaka. *Social Science & Medicine, 64*(5), 1090-1101.

Taylor, C. C. (1992). *Milk, honey, and money: changing concepts in Rwandan healing*. Washington: Smithsonian Institution Press.

Thompson, C. (2005). *Making parents: the ontological choreography of reproductive technologies*. Cambridge: MIT Press.

Thomson, J. J. (1971). A defense of abortion. *Philosophy and Public Affairs, 1*(1), 47-66.

Tinga, S. (1991). *Mobilité conjugale et fécondité à Bertoua*. Yaoundé: IFORD.

Toedter, L. J., Lasker, J., & Janssen, H. (2001). International comparison of studies using the perinatal grief scale: a decade of research on pregnancy loss. *Death Studies, 25*(3), 205-228.

Toedter, L. J., Lasker, J. N., & Alhadeff, J. M. (1988). The perinatal grief scale: development and initial validation. *American Journal of Orthopsychiatry, 58*(3), 435-449.

Tronto, J. C. (1993). *Moral boundaries: a political argument for an ethic of care*. New York: Routledge.

Tsala Tsala, J. P. (1996). Grossesse et interdits chez les Beti. *Cahiers de Sociologie Économique et Culturelle, 25*, 85-94.

Turner, A. (2000). Embodied ethnography. Doing culture. *Social Anthropology, 8*(1), 51-60.

Turner, T. (1994). Bodies and anti-bodies: flesh and fetish in contemporary social theory. In T. J. Csordas (Ed.), *Embodiment and experience. The existential ground of culture and self* (pp. 27-47). Cambridge: Cambridge University Press.

Turner, T. (1995). Social body and embodied subject: bodiliness, subjectivity, and sociality among the Kayapo. *Cultural Anthropology, 10*(2), 143-170.

UN CRC (2000). *Committee on the rights of the child. Consideration of reports submitted by states parties under article 44 of the convention. Cameroon.*

UNICEF Cameroun (2003). *Guide pratique relatif aux avances faites au gouvernement, dans le cadre de l'exécution des projets et programmes de développement*.

United Nations World Commission on Environment and Development (1987). *The Brundtland Report*.

Van Allen, J. (1972). "Sitting on a Man": colonialism and the lost political institutions of Igbo women. *Canadian Journal of African Studies, 6*(2), 165-181.

Van Beek, W. E. A. (1994). The innocent sorcerer: coping with evil in two African societies (Kapsiki & Dogon). In T. D. Blakely, W. E. A. v. Beek & D. L. Thomson (Eds.), *Religion in Africa: experience & expression* (pp. 196-228). London: James Currey.

Van de Walle, E., & Renne, E. P. (2001). *Regulating menstruation: beliefs, practices, interpretations*. Chicago: University of Chicago Press.

Van der Geest, S. (1982a). The efficiency of inefficiency. Medicine distribution in South Cameroon. *Social Science & Medicine, 16*(24), 2145-2153.

Van der Geest, S. (1982b). The secondary importance of primary health care in South Cameroon. *Culture, Medicine and Psychiatry, 6*, 365-383.

Van der Geest, S. (2010). Why are pharmaceuticals sometimes liked and sometimes disliked? *Viennese Ethnomedicine Newsletter, 12*(2-3), 15-20.

Van der Geest, S., & Hardon, A. (1990). Self-medication in developing countries. *Journal of Social and Administrative Pharmacy, 7*(4), 199–204.

Van der Sijpt, E. (2007). Marginal motherhood. The ambiguous experience of pregnancy-loss in Cameroon. *Medische Antropologie. Tijdschrift over gezondheid en cultuur, 19*(2), 245-268.

Van der Sijpt, E. (2010a). 'Filling with force': reproductive loss reconsidered. *Viennese Ethnomedicine Newsletter, 12*(2-3), 21-27.

Van der Sijpt, E. (2010b). Marginal matters: pregnancy-loss as a social event. *Social Science & Medicine, 71*(10), 1773-1779.

Van der Sijpt, E. (forthcoming-a). Focusing on force and forms in Cameroon: reproductive loss reconsidered. In S. Earle, C. Komaromy & L. Layne (Eds.), *Understanding reproductive loss: international perspectives on life, death, and fertility*.

Van der Sijpt, E. (forthcoming-b). 'The vagina does not talk': conception concealed or deliberately disclosed in Cameroon. *Culture, Health, and Sexuality*.

Van der Sijpt, E., & Notermans, C. (2010). Perils to pregnancies: on social sorrows and strategies surrounding pregnancy loss in Cameroon. *Medical Anthropology Quarterly, 24*(3), 381-398.

Van Hollen, C. C. (1994). Perspectives on the anthropology of birth. *Culture, Medicine and Psychiatry, 18*(4), 501-512.

Van Hollen, C. C. (2003). *Birth on the threshold: childbirth and modernity in South India*. Berkeley: University of California Press.

van Santen, J. (1993). Dot, commerce et contrebande: stratégies d'accumulation chez les femmes 'islamisées' de Mokolo. In P. Geschiere & P. Konings (Eds.), *Itinéraires d'accumulation au Cameroun* (pp. 301-334). Paris: Karthala.

Van Wolputte, S. (2004). Hang on to your self: of bodies, embodiment, and selves. *Annual Review of Anthropology, 33*, 251-269.

Velghe-Scherpereel, G., & van de Wouwer-Leunda, P. (1996). *Profil femmes et développement au Cameroun*. Yaoundé: Ambassade Royale des Pays-Bas.

Verhoef, H. (2005). A child has many mothers. *Childhood, 12*(3), 369-390.

Vigh, H. (2006). *Navigating terrains of war. Youth and soldiering in Guinea-Bissau*. New York: Berghahn Books.

Vincent, J.-F. (1976). *Traditions et transition: entretiens avec des femmes Beti du Sud-Cameroun: mariage et situation pré-coloniale, anciens rites de femmes, magie et sorcellerie, réactions à la christianisation*. Paris: ORSTOM.

Vincent, J.-F. (2001). *Femmes Beti entre deux mondes: entretiens dans la forêt du Cameroun*. Paris: Karthala.

Wakam, J. (1994). *De la pertinence des théories "économistes" de fécondité dans le contexte socio-culturel camerounais et negro-africain*. Yaoundé: IFORD.

Wankah, C., Ndongo, N., & Abega, M. (1998). Synthèse du rapport sur l'étude de cas de l'IB/REOSSP au Cameroun. In Ministère de la Santé Publique Cameroun (Ed.), *La mise en oeuvre de la réorientation des soins de santé primaires au Cameroun.* Yaoundé: Ministère de la Santé Publique.

Watkins, S. C. (1993). If all we knew about women was what we read in demography, what would we know? *Demography, 30*(4), 551-577.

Wembah-Rashid, J. A. R. (1996). Explaining pregnancy loss in matrilineal Southeast Tanzania. In R. Cecil (Ed.), *The anthropology of pregnancy loss: comparative studies in miscarriage, stillbirth and neonatal death*. Oxford: Berg.

Wengraf, T. (2001). *Qualitative research interviewing: biographic narrative and semi-structured methods*. New York: Sage.

Whittaker, A. (2002). 'The truth of our day by day lives': abortion decision making in rural Thailand. *Culture, Health & Sexuality, 4*(1), 1-20.

Whyte, S. R. (1997). *Questioning misfortune: the pragmatics of uncertainty in eastern Uganda*. Cambridge: Cambridge University Press.

Whyte, S. R. (2002). Subjectivity and subjunctivity: hoping for health in eastern Uganda. In R. Werbner (Ed.), *Postcolonial subjectivities in Africa* (pp. 171-190). London: Zed.

Whyte, S. R., Van der Geest, S., & Hardon, A. (2002). *Social lives of medicines*. Cambridge: Cambridge University Press.

World Health Organization (1992). *The prevention and management of unsafe abortion: report of a technical working group*. Geneva: WHO.

World Health Organization (2007). *Maternal mortality in 2005. Estimates developed by WHO, UNICEF, UNFPA and The World Bank.* Geneva: WHO.

Wynn, F. (2002). The early relationship of mother and pre-infant: Merleau-Ponty and pregnancy. *Nursing Philosophy, 3*(1), 4-14.

Yana, S. D. (1994). Fécondité et famille au Cameroun: les Bamiléké et les Pahouin (Fang-Beti-Bulu). Maîtrise de la croissance démographique et développement en Afrique.

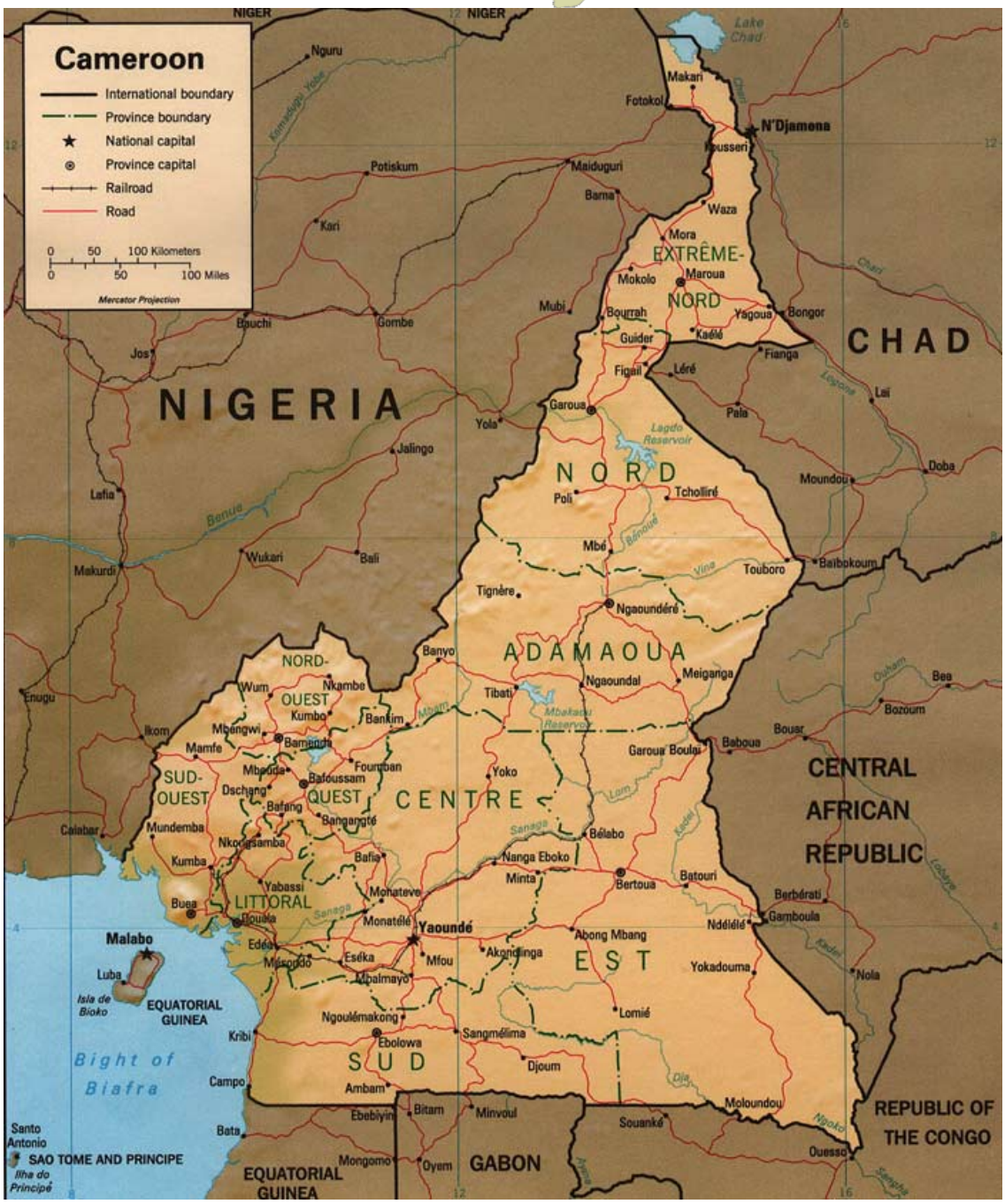
Yana, S. D. (1995). *A la recherché des modèles culturels de la fécondité au Cameroun. Une étude exploratoire aupres de Bamiléké et Beti de la ville et de la campagne*. Yaoundé: IFORD.

Yana, S. D. (1998). Conjoncture économique et constitution de la famille: une étude des représentations du mariage et de la procréation au Cameroun. In F. Gendreau (Ed.), *Crises, pauvreté et changements démographiques dans les pays du Sud* (pp. 377-392). Paris: Estem.

Zaman, S., & Chowdury, A. M. R. (1998). Exploring women's perception of reproduction through body mapping. A research note from Bangladesh. *Medische Antropologie. Tijdschrift over gezondheid en cultuur, 10*(1), 69-75.

APPENDICES

APPENDIX I: MAPS OF CAMEROON



Sources: http://web.worldbank.org and http://www.history-map.com/picture /001 /Cameroon.htm. Accessed on 15 May 2011.

APPENDIX II: FOCUS GROUP PREGNANCY INTERRUPTIONS

Vignette 1
Antoinette is a young woman of 22 years old. She has one single brother. She just married with her husband Antoine. Antoine had presented himself in Antoinette's family with traditional wine. Subsequently, Antoinette had left for Antoine's household. She stayed for 6 months without conceiving, but finally she got pregnant. She hadn't told anybody that she was pregnant. Her pregnancy leaves after 2 months.

→ How will Antoinette and her environment (husband, mother, mother-in-law) react?
→ What could possibly have caused this pregnancy interruption?
→ What will happen next in this case?

Vignette 2
Bernadette is a mother of 35 years of age, married with her husband Bernard. Bernard has paid the bride-price for his wife. In her life, she has given three children: two daughters and one son. The son died and the daughters have already gone to their marriages. Bernard would still like to have children and he just took a young co-wife into the household. Immediately, Bernadette conceives. She herself is very happy. After 6 months, the pregnancy leaves.

→ How will Bernadette and her environment (husband, co-wife, father-in-law, older brother) react?
→ What could possibly have caused this pregnancy interruption?
→ What will happen next in this case?

Vignette 3
Catherine is a 30 year old woman, who just lost her husband Jacques. She married him when she was 14 years old, and in this marriage she has already given 9 children. She often encountered difficulties during childbirth. Two children died just after birth, so seven children are alive now. Life was hard for the couple and they had to make ends meet to nourish all their children and send them to school. When Jacques died, he left his wife with her tenth pregnancy. At the day of birth, the child doesn't want to get out. The case is too difficult for the traditional birth attendant and Catherine is taken to the hospital. Three hours later, the child is stillborn.

→ How will Catherine and her environment (mother-in-law, sister, traditional birth attendant) react?
→ What could possibly have caused this pregnancy interruption?
→ What will happen next in this case?

Vignette 4
Désirée is a young girl of 17 years old, who attends the CES [secondary school] in Asung. At school, she meets a boy from Nkwej [neighbouring village] with whom she regularly has sexual intercourse, but both students do still live with their own families. At a certain moment, Désirée doesn't see her period anymore and concludes she must be pregnant. She tells this to her boyfriend. However, the boyfriend starts to insult her and denies being the father of the pregnancy, accusing her of having had sexual relationships with somebody else. Désirée starts to cry and tells her story secretly to her friend. Two months after her missed period, Désirée starts to bleed enormously and her parents have to take her to the hospital. There, it is concluded that she had been pregnant and that the pregnancy has left.

→ How will Désirée and her environment (boyfriend, father, mother, friend) react?
→ What could possibly have caused this pregnancy interruption?
→ What will happen next in this case?

APPENDIX III: FOCUS GROUP SEXUALITY AND MOTHERHOOD

Today we will discuss the story of Chantal. We will reflect on four particular moments in her life, taking into account five aspects that might play a role at these moments:

- bodily transformations
- transformation of social roles and positions
- daily life experiences
- your mother's advice with regard to this moment
- your own advice to your children with regard to this moment

1. Chantal is the first daughter in her family, living in Asung. She has 4 younger brothers. Her parents are poor and Chantal doesn't go to school. She loves to go to the fields, though, and works hard together with her mother. When Chantal is 11 years old, her small breasts start to grow. Her mother takes her *mīk* [a wooden stick which is used to prepare the local dish *couscous*] and starts to massage her daughter's chest. Chantal does not understand why this is done. She continues to work in the fields for another 2 years. One day, she returns to the village with a basin of water on her head. After storing the water in the house, she starts to do the dishes, as her mother had asked her to do. When she is sitting on the ground, she remarks that her underwear has turned red. She runs behind the house and concludes that there's blood in her underwear. She waits for her mother to return from the fields and explains the problem to her.

2. Chantal's mother advises her daughter to count all her fingers and toes before 'knowing' a man [i.e. before initiating sexual relationships]. But since Chantal doesn't have anything to do in the village, some youngsters start to flirt with her and she falls into the trap. A guy takes her to his house when his parents are absent and he asks Chantal to undress. For the very first time in her life, Chantal has sexual intercourse. Afterwards, she notices some drops of blood. She is not a virgin anymore.

3. Chantal does now know men very well. But she doesn't know how to protect herself. Since she has never gone to school, she doesn't know how to count her cycle. Her village friends have shown her indigenous remedies that do not seem to work. One day, she waits for her period, but it doesn't come. She waits until she feels a small ball in her belly. She acknowledges that she's already pregnant. Thus, not only is she a woman now, but she will also soon be a *mother of children.*

4. Chantal continues to give birth. She bears 9 children and has two abortions. Of her 9 children, six are still alive; three boys and three girls. These children also start to bear their own children. Chantal even notices that her periods becomes increasingly disordered; sometimes she bleeds twice a month, sometimes it takes three months before it comes again. At a certain point she concludes that her menstruation is over.

APPENDIX IV: FOCUS GROUP KINSHIP AND MARRIAGE

Today we will follow the life course of a hypothetical woman: Charlotte. Just like during the previous Focus Group Discussion, this case is imaginary; Charlotte doesn't exist in reality. But on the basis of her story, we will be able to discuss the different phases of marriage, their advantages and disadvantages, as well as the relation between her own family and her family-in-law in all cases. Shortly, we will discuss 7 phases in Charlotte's life:

wangang / engagement → *medokh meyal* in a far away village → *ivoula* / bride-price → polygyny → divorce → second marriage in her own village → widowhood

Now we will study these phases more profoundly by discussing each situation separately. For every phase, we will pretend that we don't know what is to follow in the future life of Charlotte. Let's start zooming in on every single situation.

1. *In the first phase Charlotte is still a young girl of 16 years old. She lives with her own family, but she already fancies village men. She gets pregnant with a guy whom she had known* [with whom she had had sexual intercourse], *who is called Antoine.*

- What do you think of sexual relationships of young girls before marriage?
- How did this happen formerly and what has changed?
- When is it good to get pregnant before marriage and when isn't it good?
- What happens between the family of the girl and the family of the guy when the girl conceives?

2. *Afterwards, Antoine recognizes he is the father of the child. After birth, he brings the* medokh meyal *and decides to take Charlotte into a village near to Yaoundé, where his family lives. She arrives as a* mom *in her new family-in-law, the members of whom she had never met before.*

- How will Charlotte's situation become now? What changes? What do you think of marriages that are this far from the village?
- When is it good to get pregnant in this initial phase of marriage and when isn't it good?
- What happens between the family-in-law and her own family – who are far removed from each other?
- How do the attitudes of her own family and of the family-in-law (so the maternal and paternal family respectively) change with regard to the children that Charlotte bears in this phase?

3. *Time flies. Charlotte bears children. Gradually, Antoine and his family give the* kanako, *the* monni niaŋa bon, *and even l'*ivoula *to the family of Charlotte here in Asung.*

- How will these transactions change Charlotte's situation?
- How will these transactions affect her desire to bear children?
- How will the relationship between her own family and her family-in-law change over time?
- How do the attitudes of her own family and of the family-in-law (so the maternal and paternal family respectively) change with regard to the children that Charlotte bears in this phase?

4. *When Antoine has paid all his obligations, he decides to take a second wife into the household. Now Charlotte has arrived at the phase of* ival *[polygyny]. The second wife also starts bearing children.*

- How does this situation affect Charlotte's childbearing intentions?
- When is it good to get pregnant in this phase of marriage and when isn't it good?
- How will this situation affect Charlotte's position within her family-in-law?

5. *After having endured for some time, Charlotte decides to leave her marriage with Antoine. She is 30 years old at this moment. She goes and stays in her own family in Asung. She takes her youngest children with her and leaves the elder ones in the family of her husband.*

- How will Charlotte's situation be within her own family? How will the people in this village consider her?
- How will this situation affect the relationship between her family-in-law and her own family?
- How do the attitudes of her own family and of the family-in-law (so the maternal and paternal family respectively), with regard to the children that Charlotte has borne in her first marriage, change at this moment?
- When is it good to get pregnant in this phase of Charlotte's life and when isn't it good?

6. *Staying in her own family now with her youngest children, a village man called Bertrand comes to fancy Charlotte. He even proposes her to come and live with him, here in the same village.*

- What will be the best decision for Charlotte in this case and why?
- What will her family advise her to do?
- How could a marriage in her own village be different than a marriage in a far away village? What are the advantages and disadvantages?

6. *Charlotte has decided to accept the marriage with Bertrand and since she is a daughter of Bibakung [one of the village's patrilineages], she goes to stay with her children in Kidong [another patrilineage in the village]. Unfortunately, after two years of marriage, Bertrand dies.*

- What will happen with Charlotte and her children in this situation?
- What will Charlotte's own family and her new family-in-law in Kidong say?
- When is it good to get pregnant in this phase of Charlotte's life and when isn't it good?
- What kind of advice would you give to Charlotte?

APPENDIX V: FOCUS GROUP KINSHIP ROLES

Today we will discuss the story of Christel. Christel encounters three situations in her life which demand public judgments. You will play the roles of different people who will be invited to assist these discussions; randomly, you will be assigned the roles of Christel's mother, her maternal uncle (*ngweej*), her niece (*mo kal*), her paternal uncle, her father-in-law, her paternal aunt, her grandmother, her sister-in-law, and her boyfriend Paul. From these points of view, you will reflect on the following three situations:

1. Christel is a daughter of the Bibakung family. She lives in this village. Her mother is a daughter of the Kidong family and a *mo kal* [niece] of the Didabi family. That is, the maternal grandmother of Christel was a daughter of the Didabi family. The mother of this grandmother was a daughter of Bélabo village. She has died already. This woman had a sister in her family [i.e. a classificatory sister] who has also passed away. This sister had gone to Yaoundé during her life and had given birth to one daughter there. This daughter, loose as she was, had conceived a child with an unknown guy in the city. Afterwards, she died due to AIDS. Thus, her little daughter did not have a mother or grandparents, and she didn't know who her father was. Therefore, she went to discover the place of the maternal uncles of her mother in Bélabo village. During this visit, she knew [i.e. had sexual intercourse with] the father of her child and bore a son, Paul. Afterwards, she also died. Paul always stayed with his father in Bélabo and had been raised by his stepmother. When Christel went for commerce to Bélabo's market, she met him. They started a relationship without knowing the connection between their great-grandmothers. When Christel finds herself pregnant, she asks Paul to go and present himself in her family. At that moment, the grandfathers of Bibakung start to trace the kinship of the two persons and detect the situation. They organize a public gathering. A discussion evolves around the question: how to continue?

2. Christel and Paul have understood the advice given to them during the previous discussion. Out of shame, the couple decides not to see each other anymore. Christel stays in her family and Paul returns to Bélabo. In her family, Christel feels ashamed every day. Her *ngweejs* [i.e. maternal uncles] of Kidong, who pass by every day on their way to their fields, constantly insult her and mock her pregnancy. The shame and anxiety with regard to the future of her child make Christel prefer to abort her pregnancy. Her mother had been informed and had accepted the idea. It is even her mother who searches for indigenous remedies [to abort], but these don't seem to work. Christel is evacuated to the hospital, while bleeding heavily. Here, 50,000 Francs are demanded for curettage. Another public gathering is now organized to discuss this situation: what are the opinions of the participants?

3. The gathering has lasted for a long time because of all the discussion points. While everybody was busy talking, Christel died even before curettage could take place. Now the corpse is still in the hospital. In order to transport Christel to the Bibakung family, the corpse will have to pass by the Kidong family. Everybody now already knows about Christel's case. In the next coming days an enormous discussion evolves before Christel is buried: where will this be and what are the roles and arguments of each person involved in the discussion?

APPENDIX VI: SURVEY QUESTIONNAIRE

Identification number:
Age:
Date of birth:
Marital status:

Familial situation

1. Do you live in your own family or in the family of your partner? (own family/family of partner/other)
2. Where do your children live?
3. Where do your children sleep?
4. Do you care for children whom you haven't borne yourself? (If yes:) How many? Whose children are they?

Matrimonial situation

5. Has the *kanako* been paid to your family? (If yes:) When?
6. Has the *monni niaŋa bon* been paid to your family? (If yes:) When?
7. Has the complete bride-price been paid for you? (If yes:) When?
8. Have you contracted a civil marriage? (If yes:) When?
9. Have you contracted a religious marriage? (If yes:) When?

Pregnancy histories

I would like to talk about all pregnancies that you have had during your life, whether they have resulted in a live birth or not. A live birth is the birth of a child who cries immediately after delivery.

10. How many live births have you had in your life?
11. Please note for every live birth: What was the child's sex? Is the child still alive? (If yes:) What is the age of the child? (If no:) At what age did the child pass away?
12. How many wasted pregnancies have you had in your life?
13. Please note for every wasted pregnancy: After how many months of pregnancy did it happen? Was it a provoked abortion or an accident? (If provoked:) How have you provoked the abortion? (If accident:) What was the cause? Which treatment have you searched afterwards?
14. Do you know women in your environment who have ever provoked an abortion? (If yes:) How many? How did they do it?
15. Have you ever suffered from the women's worm?
16. Have you ever used remedies after sexual intercourse to prevent a pregnancy from entering? (If yes:) Which remedies?

APPENDIX VII: SURVEY STATISTICS

The tables below present the survey statistics calculated on the basis of 290 completed questionnaires (see Appendix VI). However, not all questions were answered by all respondents, or not all their answers have been noted down on the forms. Consequently, the sub-totals per question might differ from the total number of 290 respondents who participated in the survey. To gain clarity in this respect, the tables present both absolute and relative values. The mode (the answer that appears most frequently) has been made bold in order to enhance quicker reading of the tables.

PERSONAL CHARACTERISTICS

Table 1. Age of respondents

< 20	48	16.7 %
20 - 24	**55**	**19.2 %**
25 – 29	42	14.6 %
30 – 34	24	8.4 %
35 – 39	21	7.3 %
40 – 44	19	6.6 %
45 – 49	12	4.2 %
50 – 54	26	9.1 %
55 – 59	4	1.4 %
60 – 64	16	5.6 %
65 – 74	15	5.2 %
75 - 112	5	1.7 %
Total	287	100 %

Table 2. Marital status of respondents

Married	**174**	**60 %**
Not married	86	29.7 %
Widowed	26	9 %
Divorced	4	1.4 %
Total	290	100 %

FAMILIAL SITUATION

Table 3. Residence of respondents

Own family	93	33.2 %
Partner's family	**178**	**63.6 %**
Other	9	3.2 %
Total	280	100 %

Table 4. Residence of respondents' children

Mother	34	14.7 %
Father	22	9.5 %
Both parents	**70**	**30.3 %**
Maternal family	34	14.7 %
Paternal family	51	22.1 %
Other relatives	6	2.6 %
Other	14	6.1 %
Total	231	100 %

Table 5. Presence of non-biological children fostered by respondents

Yes	139	48.6 %
No	**147**	**51.4 %**
Total	286	100 %

Table 6. Number of children fostered by fostering respondents

1	**39**	**32.8 %**
2	27	22.7 %
3	22	18.5 %
4	9	7.6 %
5	8	6.7 %
6	6	5 %
7	3	2.5 %
8	2	1.7 %
10	1	0.8 %
15	2	1.7 %
Total	119	100 %

Table 7. Biological parents of children fostered by fostering respondents

Brother or sister	**59**	**40.4 %**
Brother-in-law or sister-in-law	16	11 %
Husband	21	14.4 %
Son or daughter	34	23.3 %
Co-wife	3	2.1 %
Mother or father	6	4.1 %
Other	7	4.8 %
Total	146	100 %

MARITAL SITUATION

Table 8. Transfer of kanako *payments for (previously) married respondents*

Yes	109	47.4 %
No	**121**	**52.6 %**
Total	230	100 %

Table 9. Transfer of monni niaŋa bon *payment for (previously) married respondents*

Yes	89	39 %
No	**139**	**61 %**
Total	228	100 %

Table 10. Transfer of complete bride-price payments for (previously) married respondents

Yes	70	30.8 %
No	**157**	**69.2 %**
Total	227	100 %

Table 11. Civil marriage contracted by (previously) married respondents

Yes	56	24.8 %
No	**170**	**75.2 %**
Total	226	100 %

Table 12. Religious marriage contracted by (previously) married respondents

Yes	21	9.5 %
No	**200**	**90.5 %**
Total	221	100 %

REPRODUCTIVE HISTORIES

Table 13. Number of live births per respondent

0	17	6.5 %
1	**45**	**17.2 %**
2	35	13.4 %
3	44	16.8 %
4	27	10.3 %
5	20	7.6 %

6	12	4.6 %
7	18	6.9 %
8	12	4.6 %
9	13	5 %
10	6	2.3 %
11	7	2.7 %
12	4	1.5 %
13	1	0.4 %
14	1	0.4 %
Total	262	100 %

Table 14. Sex division of all live-born children of respondents

Male	**543**	**50.4 %**
Female	534	49.6 %
Total	1077	100 %

Table 15. Survival of all live-born children of respondents

Still alive	**815**	**75.7 %**
Deceased	262	24.3 %
Total	1077	100 %

Table 16. Number of 'wasted pregnancies' per respondent

0	**97**	**40.4 %**
1	93	38.8 %
2	31	12.9 %
3	12	5 %
4	3	1.3 %
5	4	1.7 %
Total	240	100 %

Table 17. Intentionality behind 'wasted pregnancies' of respondents

Provoked	25	11.2 %
Accident	**198**	**88.8 %**
Total	223	100 %

Table 18. Number of gestational months after which respondents' pregnancies were 'wasted'

1	22	10 %
2	51	23.2 %
3	**56**	**25.5 %**
4	13	5.9 %
5	21	9.6 %
6	18	8.2 %
7	8	3.6 %
8	13	5.9 %
9	18	8.2 %
Total	220	100 %

Table 19.Abortion methods used by aborting respondents

Hospital/ medical doctor/ curettage	6	24 %
Indigenous (purging barks or chemical liquids)	**15**	**60 %**
Drinking concoction of pills	1	4 %
Vaginal insertion/ needle/ opening of cervix	3	12 %
Total	25	100 %

Table 20. Reason for accidental pregnancy interruptions of respondents

Hard work	34	22.1 %
Disease (jaundice, hot water)	**75**	**48.7 %**
Women's worm	12	7.8 %
Physical shocks	12	7.8 %
Difficult or premature birth	7	4.5 %
Mystical	3	1.9 %
Other	11	7.1 %
Total	154	100 %

Table 21. Kind of treatment sought after a 'wasted pregnancy' by respondents

Hospital	**86**	**49.7 %**
Indigenous	63	36.4 %
Nothing	21	12.1 %
Other	3	1.7 %
Total	173	100 %

Table 22. Acquaintance of respondents with aborting women

Yes	91	31.6 %
No	**197**	**68.4 %**
Total	288	100 %

Table 23. Personal experience of respondents with 'women's worm'

Yes	138	47.9 %
No	**150**	**52.1 %**
Total	288	100 %

Table 24. Utilization of post-coital remedies to prevent pregnancy by respondents

Yes	28	9.7 %
No	**261**	**90.3 %**
Total	289	100 %

APPENDIX VIII: PREGNANCY-RELATED CONSULTATIONS *CSI* ASUNG

8.1 Antenatal consultations (ANCs)

Year	Number of registered ANCs
2000	102
2001	110
2002 (January - May)	40
2003 (January – August)	120
2004	138
2005	119
2006	100
2007	89
2008	43
2009 (January – August)	46

8.2 Gynaecological consultations

Year	Threat of abortion	Induced abortion	Bleeding during pregnancy	Miscarriage	Post-abortum bleeding /infection	Dys-menorrhea	Total number of patients
2003	14			4			906
2004	6			5			790
2005	3	3		1		9	992
2006	3			1	1	1	412
2007	2				1		173
2008	1	1	5		1	1	506

APPENDIX IX: PROHIBITIONS DURING PREGNANCY

Underlying rationale	To protect	Prohibition: 'A pregnant woman should not...'	Consequence if not adhered to
(Ethno)physiology	Pregnancy	Use remedies for catching fish	Miscarriage since the poison kills the child
		Work in the sun too much	Miscarriage as a consequence of the heat on a woman's back
		Carry heavy baggage	Miscarriage or stillbirth in case the woman falls
		Wear high heels	Miscarriage in case the woman falls
	Delivery	Have sexual intercourse with men other than the father of the child	Difficult childbirth since the woman has 'mixed the pregnancy' (*elle a mélangé la grossesse; apula abum mon njo*) and the child refuses all sperm other than his father's. The woman should first confess by publicly announcing all the names of her lovers before the child can be born
		Sit with closed legs	Difficult childbirth since the child might not find the opening in the vagina
	Newborn baby	Be woken up when she is sleeping	Malformed child (lacking a finger, an ear, etc.) since the process of development of the child has been interrupted during sleep
		Sit down too abruptly (towards end of pregnancy)	Damage of the child's still very delicate head
		Wear tight clothes	Malformed child since there is too much pressure on the belly and the child is not able to develop or breathe properly
		Have sexual intercourse towards the end of her pregnancy (from 7 months onwards)	The child will be born covered in a white mucus, with lesions on his body, or with 'dirt' in the eyes because of the excess sperm
	Pregnant woman	Wear somebody else's clothes	The woman will catch the same diseases as the proprietor of the clothes
Mother-foetus analogy (physical)	Delivery	Sit cross-legged	Difficult childbirth since the child will also spread his legs when he moves down
		Sleep or rest too much during the day	Difficult childbirth since the child comes out slowly
		Cut her nails	Difficult childbirth since the child cannot scratch his way out
		Wear jewellery	Child will be born with the umbilical cord wrapped around his neck
		Stay in the village without walking to the fields	Difficult childbirth since the child might move into his mother's legs
		Wear a head scarf	Child will be born with the umbilical cord wrapped around his neck
		Stand still in the door opening	Difficult or slow childbirth since the child will get stuck in the vagina
	Newborn baby	Chop wood	The child will be born with a split fontanel
		Sleep on her back	The blood of the mother will get into the eyes of the child
Mother-foetus analogy (moral)	Delivery	Quarrel with people	Difficult childbirth since the child will also be angry
	Newborn baby	Steal something	Child will be born as a thief
Food-foetus analogy	Pregnancy	Eat catfish	Miscarriage or the child will be born with a large fontanel that might split at moments of thunder and lightning (*ngól*)
		Eat fish that has been caught with remedies	Miscarriage since the poison kills the child
Food-foetus analogy	Delivery	Eat the left-over food of the preceding day ('food that has been sleeping over night')	Child will sleep during delivery and cause prolonged labour

	Newborn baby	Eat alligator	Difficult childbirth since the child will only move upward rather than downward
		Burn meat as a means of conservation	The child will be born with lesions and blisters on his skin, as if he is burnt
		Eat meat that has been partly eaten away by other animals (especially ants)	Child will be born with rash and skin lesions
		Eat the head of a pig	Child will suffer from abscesses on his head
		Eat the head of animals	The ears of the child will be filled with pus and his head will remain very delicate.
		Eat an elephant's trunk	Child will be born with a big nose
		Eat snake	Child will crawl only on his stomach, without using hands and feet
		Eat gazelle	Child will suffer from epilepsy
		Eat porcupine	Child will be born with rash and his skin could tear apart
		Eat turtle	Child will be born as a turtle
		Eat eggs	Child will be born with a bald head and closed eyes; his navel, hands, and feet will swell during life
		Eat certain forest fruits	Child will be born with a tender head
		Eat very hot sauce	Child will burn his mouth
		Eat too much pepper	Child will be born with a long tongue and red eyes and he will cry a lot
		Eat too much salt	It will swell the woman's hands and feet and the child will refuse to eat too salty food
Exposure to death	Pregnancy	Walk into a room where somebody has died	Miscarriage or stillbirth
		Assist a funeral without having attached certain remedies to the fingers or hair	Miscarriage or stillbirth
	Newborn baby	Sit down on the bed of a corpse	Child will suffer from 'disease of the corpse' (*akon mīm*) and will swell as if he is malnourished
		Walk on the spot where a corpse has been washed	Child will suffer from 'disease of the corpse' (*akon mīm*) and will swell as if he is malnourished
Exposure to supernatural forces	Pregnancy	Walk alone in the forest too often	Witchcraft attack since the witches might be alerted by the odours of pregnancy
	Newborn baby	Fetch water in the evening	The child will turn mute, since it will be attacked by the witches that had dipped their hands in the water the woman drinks
'Tradition'	Pregnancy	Sit on a bench on which lice are crushed	Miscarriage or stillbirth
		Sit on the skin of a hare (which served as a sheet for newborn babies in former times)	Miscarriage or stillbirth
		Try to kill a snake	Child will get illness *mesum* with diarrhoea and nausea in case the woman fails to kill the snake
	Newborn baby	Eat chicken without her husband	Child will get illness *mesum* with diarrhoea and nausea
		Pass by certain forest fruits	The head of the child will grow explosively

SUMMARY

How do women deal with pregnancy interruptions in a setting where fertility is highly valued and reproductive mishaps are frowned upon? How can we understand the decisions that they make during these reproductive happenings? And how are these decisions informed by social connections, individual ambitions, and bodily states? These are the main questions that gave rise to this anthropological research on pregnancy interruptions in Eastern Cameroon. During fifteen months between 2004 and 2009, I closely interacted with Gbigbil women in Asung village, and participated in reproductive and other social and personal events in their lives. Through in-depth and life story interviews, focus group discussions, conversations with partners and family members, aetiological explorations, body mapping exercises, diary distributions, and an anthro-demographical survey I sought to gain insight into the stakes and stories that surround the interruptions of their pregnancies.

Despite the frequent occurrence of reproductive mishaps, such stakes and stories have only recently come to be mentioned in anthropological literature. For a long time, ethnographic studies of human reproduction were based on normative accounts of fertility behaviour; the complexities of, and contestations around, interrupted pregnancies were hardly mentioned. Only in the 1990s did the anthropological gaze turn towards marginalized subjects and counter-hegemonic practices. The resulting explicit attention to reproductive politics and contestations led to investigations of women's experiences of both provoked and spontaneous pregnancy interruptions all over the world. Although this thesis builds upon this recent body of work, my findings also depart from it in significant ways. I argue that the existing literature is informed by three major dichotomies that hinder a deeper understanding of women's ambiguous experiences with interrupted pregnancies: 1) a time-based division of miscarriages and stillbirths; 2) a distinction between spontaneous and induced pregnancy interruptions; and 3) an association of spontaneous pregnancy interruptions with passive suffering and of induced abortions with agency.

Rather than demarcating reproductive happenings on the basis of these dichotomies and their underlying (often ethnocentric) assumptions, in this thesis I propose to look at reproductive interruptions in the broadest sense: *any* form of interrupted fertility – infertility, miscarriage, stillbirth, perinatal and neonatal death, but also induced abortion and fertility regulation – is taken as a starting point, irrespective of the gestational stage of the pregnancy or underlying intentions and associations. I seek

to *investigate,* rather than to *presuppose*, women's own definitions and categorizations of these events – as well as those instances that they downplay as non-events – and the different reproductive ambitions, decisions, and experiences related to them.

To enable this investigation, I propose framing incidents of interrupted fertility as *vital conjunctures*. Defined by Johnson-Hanks (2006, p. 22) as 'socially structured zones of possibility that emerge around specific periods of potential transformation in a life or lives', vital conjunctures capture the structures, constraints, and possible future scenarios ('horizons') that people encounter at critical turning points in their lives. Reproductive interruptions can be considered such turning points: they *potentially* transform life courses by derailing previous pathways or opening up new horizons. By focusing on the vital conjunctures that arise around these happenings, in this thesis I examine the decisions that women make and the directions that they take during different instances of interruption. I aim to shed light on *how* women (re)direct their pathways and (re)define their 'projects' – their overt or covert desires, aspirations, and ambitions (Ortner, 2006) – within the particular vital conjunctures that make up their reproductive trajectories.

Although such a focus highlights the complexity, contingency, and changeability of what I, with reference to Vigh (2006), call 'reproductive navigation', in this thesis I also trace *broader* socio-cultural mechanisms and patterns of reproductive decision-making. Inspired by Africanist debates about the inherent sociality or individuality of the body, self, and personhood, I investigate how women's navigation of reproductive conjunctures is related to – or even from the outset defined by – their interpersonal connections on the one hand and their individual bodies on the other. I seek to provide more solid ground for understanding *why* women switch their previous pathways and projects (or not) when faced with interrupted fertility, and which social, individual, or bodily characteristics influence this reproductive navigation.

In order to be able to 'situate' Gbigbil women's reproductive navigation in such a comprehensive way, I first outline the *contexts* of fertility interruptions in Part I of this thesis before describing the actual *conjunctures* that form the focus of this study in Part II. Chapter 1 demonstrates that the local political, economic, sanitary, and social 'terrains' (Vigh, 2006) in which Gbigbil women experience and manage fertility interruptions are highly unstable and unpredictable. From the late nineteenth century onwards, Gbigbil everyday life has undergone radical transformations: the previously semi-nomadic and egalitarian Gbigbil people have been forced to settle in permanent villages with officially appointed chiefs and state institutions such as schools and hospitals; colonial and post-colonial interventions have attempted to alter the intimate domains of sexuality and reproduction – with a pronatalist focus on population *growth* in this allegedly 'underpopulated' area gradually giving way to attempts to *control* fertility; the introduction of a cash economy has changed power dynamics and gendered hierarchies;

education and job opportunities have delayed entrance into marriage and shed new light on the importance of motherhood in women's lives; and the economic crisis has made it more difficult for men to assemble all elements of the bride-price.

In these transforming and uncertain settings, sexual and marital relationships are also flexible and fragile. Current realities are at odds with long-standing patrilineal and pronatalist ideals, which portray conjugal arrangements as entailing a woman living in, and bearing children for, the patrilineage of her husband, as well as a series of bride-price exchanges between both partners' families. In practice, sexual and conjugal life is often characterized by informal unions with multiple partners. Reproduction can lead to the consolidation of these relationships, but remains, at the same time, a cause of competition and uncertainty. Men might, for example, impregnate women without acknowledging their paternity; women often enter and 'endure' monogamous or polygamous marriages without consolidation through bride-price payments; and the children born to these uncertain unions are claimed by paternal *or* maternal kin – or both at the same time, or none at all. The ambiguous status that exogamously married women have always occupied – as 'outsiders' in both their husbands' and their own lineages – becomes exacerbated in the absence of any compensatory and reciprocal arrangements. Their reproduction is a site of heavy contestation.

It is within this context of reproductive uncertainty that we should consider Gbigbil women's pregnancy management. In Chapter 2, it becomes clear that in Asung pregnancies are *social* affairs. The success of reproductive happenings is contingent upon social circumstances and the goodwill of others. As fertility is always wanted by some and contested by others in the current Gbigbil kinship and marriage dynamics, pregnant bodies are often also *vulnerable* social objects – easily affected by the malicious interventions of evil co-wives, jealous female competitors, or discontented relatives and in-laws. In contrast to the explicit focus on risks *of* pregnancies in current global reproductive health debates, Gbigbil women emphasize risks *to* pregnancies, often coming from others. Consequently, they shroud early pregnancy in silence and attempt to accelerate and hide the moment of childbirth – for it is during the vulnerable first and last phases of a pregnancy that malevolent others can most easily attack.

Even if pregnant bodies can be seen as *social* bodies, pregnant women still have room for individual management and tactical manipulation. They prove to be what I call 'pragmatic patients' in combining various (indigenous and biomedical) forms of pregnancy care, and creatively deploy different discourses on fertility and foetal development. Gbigbil embryological ideas portray a gradual development from an initial state of liquid 'void', via a ball of blood or a lizard-like creature called *zəng mon*, into a human-like being called *mon* ('child'). As the gradual development of foetal forms and 'force' (*ngul*) is thought to depend on the variable amount and quality of both parents' blood, embryological processes are highly person-dependent and never completely knowable. This allows for inventive interpretations of what a pregnancy constitutes at a

certain moment; it provides individual women leeway to decide on the future of 'potential' foetuses – with 'evacuations' being common and passing unnoticed during the hidden first phase of a pregnancy – but also to redefine and contest the viability and prematurity of their newborn babies.

This observed tension between social entanglement and individual tactics during pregnancy raises the question of how sociality and individuality are at play in women's navigation of vital conjunctures around pregnancy *interruptions*. In Chapters 3 and 4, I attend to the dynamics of reproductive navigation of Gbigbil women who live and wish to stay in Asung, and those who envisage a future in the city, respectively. In both chapters I analyze how the particular aspirations that women hold at certain points and pathways in their lives affect, and are affected by, the socially structured situations they encounter around fertility interruptions. The aim is to understand *why* women take certain directions and make different decisions during their reproductive conjunctures. The aspirations of women aiming for *rural* respectability are largely informed by local ethics of production and reproduction; 'good' womanhood, wifehood, and motherhood is to be achieved through hard work in the fields, food preparation, and childbearing – preferably within a marital framework. Fertility interruptions form a threat to rural respectability because they involve a loss of blood and force, and thus affect women's activities related to their 'field, fire, and fertility'. The inability to live up to the local ethics of production and reproduction often exacerbates women's ambiguous position as outsiders in the patrilineages of their husbands or as potential wives on a flexible marriage market. The loss of *physical* force as a result of fertility interruptions can thus have severe *social* ramifications. Women's navigation of such critical reproductive moments – the ways in which they (re)direct previous pathways to, and projects of, rural respectability – depends on the social support they receive from their own family and their in-laws. Their possession of other forms of capital such as education or employment – that would open up horizons towards realms of respect *beyond* the domains of field, fire, and fertility – also defines which decisions women (can) make in such situations.

When physical force, social support, and other forms of capital are absent, however, rural women facing (repeated) reproductive misfortune still find ways to inventively reassert their stakes and ambitions in line with the contexts of their conjunctures. Not only do they reinterpret the meanings of good womanhood, wifehood, and motherhood, they also redefine what has actually been lost. The contingent 'filling with force' of Gbigbil babies during and after pregnancy leads to a rather fuzzy distinction between the loss of a 'pregnancy' and the loss of a 'child' in the case that fertility is interrupted. The boundaries that women draw between different forms of reproductive interruptions are thus more ambiguous than the ones between strict time-based biomedical categories (such as miscarriages, stillbirths, perinatal, and neonatal deaths – informing the first predominant dichotomy in the literature on reproductive loss as well).

Consequently, women can choose to stress one ('pregnancy loss') or the other ('child death') and in this way downplay or dramatize their reproductive happenings. The meanings of particular pregnancy interruptions are constantly adjusted according to women's personal projects and the social situations at hand.

Negotiations and situational adaptations are part and parcel of *all* instances of reproductive navigation. But they acquire different forms when pregnancies are interrupted during women's pathways to *urban* respectability. In Chapter 4 I show that when women aim for a life in the city, their ambitions related to the fields, fire-side, and fertility give way to alternative aspirations of education, employment, or sexual liaisons with rich men called 'big fish'. A pregnancy occurring in this context may be considered a hinderance to an urban future, a tool to convince a promising partner to engage, or a disruptive element to an unstable urban affair in which both partners may have aims other than partnerhood or parenthood. Even if marriage and motherhood remain the *ultimate* frameworks of respectability in life, the desirability of fertility is often contradictory, temporal, and situational for women with urban aspirations; the fate of their foetuses becomes explicitly bargained within their precarious partnerships.

Reproductive interruptions can be the *consequence* of these relational ambiguities, because women may resort to abortions in the face of urban uncertainty. They can also be the *cause* of further ambiguities (and possibly the end of an urban relationship) because they may raise suspicions about women's deliberate efforts to limit offspring. Accusations of witchcraft – the offering of foetal tissue in occult nightly gatherings – or abortion are prone to erupt in cases of interrupted fertility, contributing to the distrust that pervades most urban affairs. Abortion suspicions are, however, not completely unsubstantiated: many women perform post-coital menstrual inducements or may interrupt their pregnancies at a later stage. This is done with the aid of indigenous remedies, folk methods, contraindicated biomedical pills, or the services of biomedical doctors and abortion specialists in remote neighbourhoods. Yet, while everyone is familiar with these possibilities and practices, almost nobody knows for certain whether a particular pregnancy interruption was indeed provoked, or not.

As the intentionality behind reproductive mishaps remains often indeterminate – especially when women (are known to) have unclear fertility aims or clear alternative aspirations – the supposed dichotomy between spontaneous and induced loss becomes blurred. Provoked abortions are often presented as spontaneous ones; spontaneous abortions are often suspected to be provoked. Women can use this 'grey area' to assert their urban aspirations: they may tactically use embryological notions and aetiological explanations to turn contested reproductive interruptions into opportunities to preserve their pathways and pursue their projects. Such tactics are especially effective if women posses certain forms of capital such as a respectful background in the village, education, employment, or living children.

Irrespective of the *particular* pathways and projects that Gbigbil women prefer at certain moments in life – be they rural or urban – they seem to have a common way of negotiating and justifying their navigational choices within their webs of social relationships. In Chapter 5, which focuses on the question of *how* (rather than *why*) Gbigbil women navigate their reproductive conjunctures, I stress the importance of 'paradoxical portrayals of powerlessness' in the management of all forms of reproductive interruption – ranging from infertility to induced abortions. Seemingly passive idioms of suffering, fate, resignation to religious dogma, and submission to patriarchy paradoxically create room for tactics. Under the veil of powerlessness, women with different reproductive experiences exert their '*politiques*' within different social settings. They appropriate and reinterpret dominant discourses about distress, religion, gender, or patriarchy in order to make their voice heard, pursue their projects without upsetting the dominant order, or even *challenge* existing frameworks with 'hidden transcripts' (Scott, 1990) of female worth and power. Suffering and agency are dialectically related in ways that defy the dominant dichotomous way of thinking in much of the current literature on women's reproductive power and passivity. Contrary to common assumptions, suffering and agency are at play in both infertility and abortion – as well as in all other forms of interrupted reproduction – and are experienced by women with rural and urban aspirations alike.

Having explored *why* and *how* women navigate their reproductive conjunctures in this East Cameroonian context, I draw conclusions by discussing the different forms of sociality, individuality, and corporality that influence women's (rural or urban) pathways and projects (related to motherhood and wifehood), as well as their decisions to alter these during moments of interrupted fertility. I argue that such decisions are never 'free' choices, but that reproductive navigation is always circumscribed by different *social* configurations. A woman's pathways and projects, and the ways in which she can redirect these during reproductive conjunctures, are related to: 1) her position within a wider network of kinship relations; 2) the position of her kin group within the village; 3) her social connections to urban areas; 4) the particularities of her relationship with the (potential) father of the unborn child; 5) the proximity of unrelated others with stakes in her fertility; and 6) her personal reproductive trajectory. As all these social configurations form possibilities for or constraints to women's realization of their ambitions, reproductive decision-making is always socially contingent – or even, considering the interrelation of women's navigation with the situated navigations of others, *inter*contingent.

This inherent sociality, however, does not prevent women from having *personal* aspirations nor from using *individual* tactics to manoeuvre and manipulate the social order. I argue that a certain degree of individuality has always been, and continues to be, relevant for the Gbigbil: it served as a 'social asset' in their pre-colonial semi-nomadic and

egalitarian society where status was to be achieved on the basis of personal characteristics; it results from Gbigbil women's current ambiguous position as wives, offering them room for individual mobility and manipulation; and it is required in the ever-changing 'terrains' that people can only navigate through *judicious opportunism* – pragmatic improvisation rather than *a priori* rationalization (Johnson-Hanks, 2005). Individuality and improvisation are also present and appreciated in the domain of reproduction, and are made possible by the privacy and silence around early pregnancy. Fertility is thus fraught with ambiguity – inherently social and individual at the same time.

While social and individual dynamics are crucial for our understanding of reproductive navigation, I demonstrate in this thesis that *physical* experiences also affect women's decisions around interrupted fertility. The material body does not only enable or constrain women's social navigation, but, due to its unpredictability, needs to be navigated *itself* as well. Women have to constantly manage the broad range of options, outcomes, and obstacles their (previously) pregnant bodies present to them. Their attempts to align these unpredictable physicalities with their social projects – that is, to subject their bodily navigation to social navigation – are not always successful in the face of limited methods of intervention and the physical body's inherent capacity to conceive and release pregnancies. Judicious opportunism is therefore as much at play at the level of the body as in the uncertain and unpredictable social situations that Gbigbil women encounter in their daily lives. The dynamics of reproductive decision-making cannot be fully captured, I argue, without taking those 'body basics' into account.

In this all-encompassing framework – integrating sociality, individuality, and corporeality – the notion of vital conjunctures and Africanist insights on the social body are relevant, but not sufficient. Although the former allowed me to unravel the minutiae of ambiguous individual decision-making within changing social contexts, and the latter helped me to point out the social relations informing reproductive behaviour, both notions ignore the material 'body basics' that underlie reproduction. The comprehensive focus that I work out in this thesis further contributes to understandings of reproductive decision-making by moving beyond the analytical dichotomies that often pervade current studies in this area; by countering overly political analyses of reproductive pragmatics that overlook the pragmatics of the physical body; and by contesting common notions of reproductive choice and control that inform much of the contemporary reproductive health programs and policies.

SAMENVATTING

Hoe gaan vrouwen om met zwangerschapsonderbrekingen in een samenleving waar vruchtbaarheid hoog in het vaandel staat en reproductief verlies misprezen wordt? Hoe kunnen we de beslissingen die zij nemen tijdens zulke reproductieve gebeurtenissen begrijpen? En hoe worden deze beslissingen beïnvloed door sociale relaties, individuele ambities, en lichamelijke gesteldheid? Dit zijn de voornaamste vragen die aanleiding hebben gegeven tot dit antropologische onderzoek naar zwangerschapsonderbrekingen in Oost Kameroen. Gedurende vijftien maanden tussen 2004 en 2009 heb ik nauw samengeleefd met Gbigbil vrouwen in het dorp Asung en participeerde ik in reproductieve en andere sociale en persoonlijke gebeurtenissen in hun leven. Door middel van diepte-interviews, het optekenen van levensverhalen, focus groep discussies, gesprekken met partners en familieleden, etiologische verkenningen, lichaamstekeningen (*body mapping*), het uitdelen van dagboeken en een antropologisch-demografische enquête probeerde ik inzicht te verkrijgen in de belangen en verhalen rondom de onderbrekingen van hun zwangerschappen.

Hoewel reproductief verlies veel voorkomt worden zulke belangen en verhalen slechts sinds kort besproken in antropologische literatuur. Lange tijd waren etnografische studies naar menselijke voortplanting gebaseerd op normatieve verhandelingen van gedrag rondom vruchtbaarheid; de complexiteit van, en controverses rondom, onderbroken zwangerschappen werden nauwelijks genoemd. Pas in de jaren ’90 van de vorige eeuw wendde de antropologische blik zich tot marginale onderwerpen en tot praktijken die tegen de heersende normen van een samenleving ingaan. De expliciete aandacht voor reproductieve strategieën en controverses die daarvan het gevolg was leidde tot onderzoek naar de ervaringen van vrouwen overal ter wereld met zowel opgewekte als spontane zwangerschapsonderbrekingen. Hoewel dit proefschrift voortbouwt op dit recente werk, wijken mijn bevindingen er ook aanmerkelijk van af. Ik betoog dat de bestaande literatuur wordt ingegeven door drie belangrijke dichotomieën, die een dieper inzicht in de ambigue ervaringen van vrouwen met onderbroken zwangerschappen in de weg staan: 1) een op tijd gebaseerd onderscheid tussen miskramen en doodgeboortes; 2) een onderscheid tussen spontane en geïnduceerde zwangerschapsonderbrekingen; en 3) een associatie van spontane zwangerschaps-onderbrekingen met passief lijden en van geïnduceerde abortussen met bewust handelen (*agency*).

In plaats van reproductieve gebeurtenissen te onderscheiden op basis van deze dichotomieën en hun daaraan ten grondslag liggende (vaak etnocentrische) aannames, stel ik in dit proefschrift voor om te kijken naar reproductieve onderbrekingen in de breedste zin van het woord: *iedere* vorm van onderbroken vruchtbaarheid – onvruchtbaarheid, miskramen, doodgeboortes, perinatale en neonatale sterfte, maar ook opgewekte abortussen en vruchtbaarheidsregulatie – wordt als uitgangspunt genomen, ongeacht de ontwikkelingsfase van de zwangerschap of de onderliggende intenties en associaties. Ik wil *onderzoeken* in plaats van *vooronderstellen,* hoe vrouwen zelf deze gebeurtenissen – alsmede de gevallen die zij afdoen als 'betekenisloos' (*non-events*) – definiëren en categoriseren, en welke ambities, beslissingen en ervaringen daarmee samenhangen.

Om een dergelijke verkenning mogelijk te maken, stel ik voor om incidenten van onderbroken vruchtbaarheid te zien als *vital conjunctures* ('mogelijke keerpunten in het leven'). *Vital conjunctures*, die door Johnson-Hanks (2006, p. 22) gedefinieerd worden als '*socially structured zones of possibility that emerge around specific periods of potential transformation in a life or lives*', hebben betrekking op de structuren, beperkingen en mogelijke toekomstscenarios (*horizons*) waar mensen mee te maken krijgen tijdens mogelijke keerpunten in hun leven. Reproductieve onderbrekingen kunnen als zulke mogelijke keerpunten beschouwd worden: zij kunnen de levensloop veranderen door voorgaande levenspaden (*pathways*) te verleggen en door nieuwe *horizons* aan de dag te brengen. Via een focus op de *vital conjunctures* die rondom deze gebeurtenissen ontstaan bestudeer ik in dit proefschrift de beslissingen die vrouwen nemen en de richtingen die zij inslaan tijdens verschillende momenten van vruchtbaarheidsonderbreking. Ik wil licht werpen op de wijze waarop vrouwen (een nieuwe) richting geven aan hun levenspaden en hoe zij hun 'projecten' – hun openlijke of heimelijke wensen, aspiraties en ambities (Ortner, 2006) – (her)definiëren tijdens de diverse *vital conjunctures* die hun reproductieve trajecten vormgeven.

Hoewel een zodanige focus de complexiteit, contextafhankelijkheid en veranderlijkheid belicht van wat ik, verwijzend naar Vigh (2006), 'reproductieve navigatie' noem, traceer ik in dit proefschrift ook *bredere* sociaal-culturele mechanismes en patronen van reproductieve besluitvorming. Geïnspireerd door debatten binnen de Afrikanistiek over het inherente sociale dan wel individuele karakter van het lichaam, de zelf en persoonlijkheid, onderzoek ik hoe de navigatie van *vital conjunctures* door vrouwen samenhangt met – of zelfs vanaf het begin bepaald wordt door – aan de ene kant hun sociale connecties, en aan de andere kant hun individuele lichamen. Ik tracht een meer solide basis te bieden om te begrijpen *waarom* vrouwen hun voorgaande paden en projecten veranderen (of niet) wanneer zij te maken hebben met onderbroken vruchtbaarheid en welke sociale, individuele of lichamelijke kenmerken deze reproductieve navigatie beïnvloeden.

Om de reproductieve navigatie van Gbigbil vrouwen op een zodanig veelomvattende wijze te kunnen situeren, schets ik in Deel I van dit proefschrift eerst de *contexten* van vruchtbaarheidsonderbrekingen voordat ik in Deel II de eigenlijke *conjunctures* beschrijf die de focus van deze studie vormen. In hoofdstuk 1 laat ik zien dat de lokale politieke, economische, sanitaire en sociale 'terreinen' (Vigh, 2006) waarin Gbigbil vrouwen vruchtbaarheidsonderbrekingen meemaken erg onstabiel en onvoorspelbaar zijn. Sinds het einde van de negentiende eeuw is het alledaagse leven van de Gbigbil onderhevig geweest aan radicale veranderingen: de voorheen semi-nomadische en egalitaire Gbigbil bevolking werd gedwongen om zich te vestigen in permanente dorpen met van overheidswege aangestelde leiders en instituties zoals scholen en ziekenhuizen; koloniale en postkoloniale interventies beoogden de intieme domeinen van seksualiteit en voortplanting te veranderen – waarbij een pronatalistische focus op bevolkings*groei* in dit vermeende 'onderbevolkte' gebied langzaamaan vervangen werd door pogingen om vruchtbaarheid te *beperken*; de introductie van een geldeconomie heeft machtsrelaties en genderhierarchieën veranderd; onderwijs en veranderende beroepsmogelijkheden leidden ertoe dat mensen later trouwden en wierpen nieuw licht op het belang van moederschap in het leven van vrouwen; en de economische crisis heeft het mannen moeilijker gemaakt om alle onderdelen van de bruidsprijs te vergaren.

In deze veranderende en onzekere omgeving zijn seksuele en huwelijksrelaties net zo flexibel en kwetsbaar. Huidige realiteiten stroken niet met gewortelde patrilineaire en pronatalistische idealen, die een huwelijk voorstellen als een arrangement waarbij een vrouw woont bij, en kinderen baart voor, de patrilinie van haar man en waarbij een reeks bruidsprijstransacties tussen de families van beide partners plaatsvindt. In de praktijk wordt het seksueel en echtelijk leven vaak gekenmerkt door informele verbintenissen met meerdere partners. Reproductie kan leiden tot een versterking van deze relaties, maar blijft tegelijkertijd een bron van competitie en onzekerheid. Mannen kunnen bijvoorbeeld vrouwen zwanger maken zonder hun vaderschap te erkennen; vrouwen gaan vaak monogame of polygame huwelijken aan en 'doorstaan' deze zonder bevestiging door bruidsprijsbetalingen; en de kinderen die in deze onzekere relaties worden geboren, worden opgeëist door de familie van hun vader *of* die van hun moeder – of door beiden tegelijkertijd, of door geen van allen. De ambigue status die exogaam gehuwde vrouwen altijd al hebben gehad – als 'buitenstaanders' in hun eigen families en in die van hun echtgenoten – wordt versterkt wanneer enige compensatie of reciproke overeenkomst afwezig is. Hun reproductie is het object van hevige betwisting.

Het is in deze context van reproductieve onzekerheid dat we de omgang van Gbigbil vrouwen met hun zwangerschappen moeten plaatsen. In hoofdstuk 2 wordt duidelijk dat zwangerschappen in Asung *sociale* aangelegenheden zijn. Het succes van reproductieve gebeurtenissen hangt af van sociale omstandigheden en van de goede wil van anderen. Omdat vruchtbaarheid altijd door sommigen gewild en door anderen

betwist wordt in de huidige Gbigbil verwantschaps- en huwelijksomstandigheden zijn zwangere lichamen ook vaak *kwetsbare* sociale objecten – makkelijk te beïnvloeden door de kwaadaardige interventies van slechte co-vrouwen, jaloerse vrouwelijke concurrenten of ontevreden familieleden en schoonfamilie. In tegenstelling tot de expliciete focus op risico's *van* zwangerschappen in de huidige globale debatten over reproductieve gezondheid benadrukken Gbigbil vrouwen risico's *voor* zwangerschappen, die vaak afkomstig zijn van anderen. Dientengevolge hullen zij hun vroege zwangerschap in stilte en trachten zij het moment van bevallen te versnellen en te verbergen – want het is tijdens de kwetsbare eerste en laatste fases van een zwangerschap dat kwaadwillende anderen het makkelijkst kunnen toeslaan.

Hoewel zwangere lichamen gezien kunnen worden als *sociale* lichamen, hebben zwangere vrouwen toch ruimte voor individuele controle en tactische manipulatie. Zij zijn wat ik noem 'pragmatische patiënten' door verschillende (biomedische en traditionele) vormen van zwangerschapszorg te combineren, en zij hanteren verschillende discoursen over vruchtbaarheid en foetale ontwikkeling op een creatieve manier. De ideeën van de Gbigbil over de ontwikkeling van het embryo gaan uit van een geleidelijke ontplooiing van een initiële staat van vloeibare 'leegte', via een bloedbal of een hagedis-achtig wezen genaamd *zəng mon*, tot een menselijk wezen dat *mon* ('kind') wordt genoemd. Aangezien de graduele ontwikkeling van foetale vormen en 'kracht' (*ngul*) volgens hen afhangt van de variabele hoeveelheid en kwaliteit van het bloed van beide ouders zijn embryologische processen uiterst persoonsgebonden en nooit volledig te kennen. Dit maakt inventieve interpretaties mogelijk van wat een zwangerschap op een bepaald moment voorstelt; het geeft individuele vrouwen de vrijheid om te beslissen over de toekomst van 'potentiële' foetussen – waarbij 'verwijderingen' gangbaar zijn en onopgemerkt voorbij gaan tijdens de verborgen eerste fase van een zwangerschap – maar ook om de levensvatbaarheid en prematuriteit van hun pasgeboren baby's te herinterpreteren of te betwisten.

Deze geobserveerde spanning tussen sociale verwevenheden en individuele tactieken leidt tot de vraag op welke manieren socialiteit en individualiteit van belang zijn in de navigatie van *vital conjunctures* rond zwangerschaps*onderbrekingen*. In hoofdstuk 3 en 4 bestudeer ik de dynamiek van reproductieve navigatie van respectievelijk Gbigbil vrouwen die in Asung wonen en daar willen blijven, en van hen die een toekomst in de stad voor zich zien. In beide hoofdstukken analyseer ik hoe de specifieke aspiraties die vrouwen op bepaalde punten en paden in hun leven hebben invloed uitoefenen op, en beïnvloed worden door, de sociaal gestructureerde situaties rondom vruchtbaarheids-onderbrekingen. Het doel is te begrijpen *waarom* vrouwen bepaalde richtingen inslaan en verschillende beslissingen maken tijdens hun reproductieve *conjunctures.* De aspiraties van vrouwen die respect willen verkrijgen in *rurale* gebieden worden grotendeels ingegeven door de lokale moraal van productie en reproductie; men wordt een 'goede'

vrouw, echtgenote en moeder door hard te werken op de velden, voedsel te bereiden en kinderen te baren – bij voorkeur binnen een huwelijk. Vruchtbaarheidsonderbrekingen vormen een bedreiging voor een dergelijk respect omdat zij gepaard gaan met verlies van bloed en kracht, en op die manier de activiteiten van vrouwen ten aanzien van hun 'veld, vuur en vruchtbaarheid' belemmeren. Het onvermogen om de lokale moraal van productie en reproductie na te leven verergert vaak de ambigue positie van vrouwen als buitenstaanders in de patrilinie van hun echtgenoten of als potentiële echtgenotes op een flexibele huwelijksmarkt. Het verlies van *fysieke* kracht als gevolg van vruchtbaarheidsonderbrekingen kan dus sterke *sociale* consequenties hebben. De navigatie van zulke kritieke reproductieve momenten – de manieren waarop vrouwen hun voorgaande paden naar, en projecten met betrekking tot, respect in rurale gebieden (opnieuw) richting geven – hangt af van de sociale steun die zij van hun familie en hun schoonfamilie ontvangen. Daarnaast is het bezit van andere vormen van kapitaal zoals onderwijs of een beroep – die *horizons* naar vormen van respect *buiten* de domeinen van veld, vuur en vruchtbaarheid zouden kunnen openen – van belang voor de keuzes die vrouwen in zulke situaties (kunnen) maken.

Wanneer fysieke kracht, sociale steun en andere vormen van kapitaal echter afwezig zijn, blijken rurale vrouwen die (herhaalde) zwangerschapsonderbrekingen meemaken toch nog manieren te vinden om inventief, in overeenstemming met de contexten van hun *conjunctures,* hun belangen en ambities te verzekeren. Zij herinterpreteren niet alleen wat het betekent om een goede vrouw, echtgenote of moeder te zijn, maar herdefiniëren ook wat zij eigenlijk verloren hebben. Het persoonsgebonden 'vullen met kracht' van Gbigbil baby's tijdens en na de zwangerschap leidt tot een nogal vaag onderscheid tussen het verlies van een 'zwangerschap' en het verlies van een 'kind' wanneer vruchtbaarheid onderbroken wordt. De door vrouwen gehanteerde grenzen tussen verschillende vormen van reproductieve onderbrekingen zijn dus meer ambigu dan de grenzen tussen strikte tijdsgebaseerde biomedische categorieën (zoals miskramen, doodgeboortes, perinatale en neonatale sterfte – categorieën die ook ten grondslag liggen aan de eerste dominante dichotomie in de literatuur over reproductief verlies). Het gevolg is dat vrouwen ervoor kunnen kiezen om het één ('zwangerschapsverlies') of het ander ('kindersterfte') te benadrukken en op die manier hun reproductieve gebeurtenissen te bagatelliseren of te dramatiseren. De betekenissen van specifieke zwangerschapsonderbrekingen worden constant aangepast al naar gelang de persoonlijke projecten van vrouwen en de specifieke sociale situaties waarin zij zich bevinden.

Onderhandelingen en situationele aanpassingen maken deel uit van *alle* gevallen van reproductieve navigatie. Zij nemen echter een andere vorm aan wanneer zwangerschappen onderbroken worden als vrouwen paden richting een respectvol bestaan in de stad bewandelen. In hoofdstuk 4 laat ik zien dat wanneer vrouwen een leven in de stad voor ogen hebben, zij hun ambities met betrekking tot hun velden, vuur

en vruchtbaarheid opzij zetten voor alternatieve aspiraties gerelateerd aan onderwijs, werkgelegenheid of seksuele verhoudingen met rijke mannen die 'grote vissen' ('*gros poissons*') worden genoemd. In deze context kan een zwangerschap worden beschouwd als een belemmering voor een urbane toekomst, een mogelijkheid om een veelbelovende partner aan zich te binden, of een storende factor binnen een onstabiele urbane relatie waarin beide partners andere doelen dan partnerschap of ouderschap kunnen hebben. Hoewel huwelijk en moederschap de *uiteindelijke* bronnen van respect vormen in het leven, is de wenselijkheid van vruchtbaarheid voor vrouwen met stadsambities vaak tegenstrijdig, tijdelijk en situationeel; het lot van hun foetussen wordt expliciet onderhandeld binnen hun precaire partnerschappen.

Reproductieve onderbrekingen kunnen het *gevolg* zijn van deze relationele ambiguïteiten, omdat vrouwen hun toevlucht nemen tot abortussen wanneer ze geconfronteerd worden met urbane onzekerheid. Ze kunnen ook de *oorzaak* zijn van verdere ambiguïteiten (en mogelijk ook het einde van een urbane relatie) omdat ze argwaan kunnen opwekken over doelbewuste pogingen van vrouwen om hun nakomelingschap te beperken. Beschuldigingen van hekserij – het offeren van foetaal weefsel tijdens occulte nachtelijke bijeenkomsten – of abortus liggen altijd op de loer in gevallen van vruchtbaarheidsonderbreking, hetgeen het wantrouwen versterkt dat in de meeste urbane relaties aanwezig is. Verdenkingen van abortuspleging zijn echter niet compleet ongegrond: veel vrouwen wekken na seksueel contact hun menstruatie op of breken op een later moment hun zwangerschappen af. Zij doen dit met behulp van inheemse remedies, traditionele methoden, biomedische pillen die tijdens de zwangerschap afgeraden worden, of de diensten van biomedische artsen en abortusspecialisten in afgelegen wijken. Alhoewel iedereen bekend is met deze mogelijkheden en praktijken weet bijna niemand zeker of een bepaalde zwangerschapsonderbreking inderdaad opgewekt was of niet.

Aangezien de intentionaliteit achter reproductieve incidenten vaak onduidelijk blijft – vooral wanneer (men weet dat) vrouwen onduidelijke kinderwensen of duidelijke alternatieve aspiraties hebben – vervaagt de veronderstelde dichotomie tussen spontaan en geïnduceerd verlies. Opgewekte abortussen worden vaak gepresenteerd als spontane abortussen; spontane abortussen worden er vaak van verdacht te zijn opgewekt. Vrouwen kunnen dit 'grijze gebied' gebruiken om hun urbane aspiraties te bevestigen: door bepaalde embryologische noties en etiologische verklaringen te benadrukken kunnen zij controversiële reproductieve onderbrekingen aanwenden om hun paden te verzekeren en hun projecten na te streven. Zulke tactieken werken vooral als vrouwen verschillende vormen van kapitaal bezitten zoals een respectvolle achtergrond in het dorp, een bepaald niveau van onderwijs, een baan of levende kinderen.

Ongeacht de *specifieke* levenspaden en projecten waaraan Gbigbil vrouwen de voorkeur geven op bepaalde momenten in het leven – zij het ruraal of urbaan – lijken zij

een overeenkomstige manier te hebben waarop zij over hun navigatiekeuzes onderhandelen en deze rechtvaardigen binnen hun sociale netwerken. In hoofdstuk 5, dat focust op de vraag *hoe* (in plaats van *waarom*) Gbigbil vrouwen hun reproductieve *conjunctures* navigeren, benadruk ik het belang van 'paradoxale voorstellingen van machteloosheid' (*paradoxical portrayals of powerlessness*) in het omgaan met alle vormen van reproductieve onderbreking – variërend van onvruchtbaarheid tot geïnduceerde abortussen. Schijnbaar passieve idiomen over lijden, het lot, overgave aan religieus dogma en onderwerping aan de patriarchie creëren op een paradoxale manier ruimte voor bewust gehanteerde tactieken. Onder het mom van machteloosheid oefenen vrouwen met verschillende reproductieve ervaringen hun 'politiek' uit binnen verschillende sociale omgevingen. Zij eigenen zich dominante discoursen over leed, religie, gender of patriarchie toe en herinterpreteren deze om hun stem te laten horen, hun projecten na te streven zonder de dominante orde om te werpen, of zelfs bestaande raamwerken te *betwisten* met 'verborgen transcripten' (Scott, 1990) over vrouwelijke waarde en macht. Lijden en *agency* staan in een dialectische relatie tot elkaar op een manier die niet strookt met de dominante dichotome manier van denken in veel huidige literatuur over de reproductieve macht en passiviteit van vrouwen. In tegenstelling tot gangbare aannames zijn lijden en *agency* aanwezig in zowel onvruchtbaarheid als abortus – en in alle andere vormen van onderbroken reproductie – en worden zij ervaren door vrouwen met zowel rurale als urbane aspiraties.

Na deze verkenning van *waarom* en *hoe* vrouwen hun reproductieve *conjunctures* navigeren in deze Oost Kameroense context, trek ik conclusies middels een uiteenzetting van verschillende vormen van socialiteit, individualiteit en lichamelijkheid die hun invloed uitoefenen op de (rurale of urbane) paden en (aan moederschap of huwelijk gerelateerde) projecten van vrouwen, en op hun beslissingen om deze te veranderen tijdens momenten van vruchtbaarheidsonderbreking. Ik betoog dat zulke beslissingen nooit 'vrije' keuzes zijn, maar dat reproductieve navigatie altijd onlosmakelijk verbonden is met verschillende *sociale* configuraties. De levenspaden en projecten van een vrouw, en de manieren waarop zij deze (een nieuwe) richting kan geven tijdens reproductieve *conjunctures*, hangen samen met: 1) haar positie binnen een breder netwerk van verwantschapsrelaties; 2) de positie van haar verwantschapsgroep binnen het dorp; 3) haar sociale connecties met urbane gebieden; 4) de kenmerken van haar relatie met de (potentiële) vader van het ongeboren kind; 5) de nabijheid van niet-verwante anderen die belang hebben in haar vruchtbaarheid; en 6) haar persoonlijke reproductieve traject. Aangezien al deze sociale configuraties mogelijkheden of beperkingen kunnen vormen voor de verwezenlijking van de ambities van vrouwen is reproductieve besluitvorming altijd sociaal *contingent* ('afhankelijk van sociale omstandigheden') – of zelfs, gezien de verbondenheid van de navigatie van vrouwen met de gesitueerde navigatie van anderen, *intercontingent* ('afhankelijk van de omstandigheden van anderen').

Deze sociale verwevenheden weerhouden vrouwen er echter niet van om *persoonlijke* aspiraties te hebben of *individuele* tactieken te gebruiken om zich door de sociale orde te manoeuvreren en deze te manipuleren. Ik betoog dat een zekere mate van individualiteit altijd relevant is geweest voor de Gbigbil, en dat ook nog steeds is: het diende als 'sociaal kapitaal' in hun prekoloniale semi-nomadische en egalitaire samenleving waar status verkregen diende te worden op basis van persoonlijke kenmerken; het is een gevolg van de huidige ambigue positie van Gbigbil vrouwen als echtgenotes, hetgeen hen ruimte biedt voor individuele mobiliteit en manipulatie; en het is vereist in de steeds veranderende 'terreinen' die mensen enkel kunnen navigeren door *judicious opportunism* ('oordeelkundig opportunisme') – pragmatische improvisatie in plaats van *a priori* rationalisatie (Johnson-Hanks, 2005). Individualiteit en improvisatie zijn ook aanwezig en gewaardeerd in het domein van reproductie, en worden mogelijk gemaakt door de privacy en stilte rondom vroege zwangerschappen. Vruchtbaarheid is dus doordrongen van ambiguïteit – het is tegelijkertijd sociaal en individueel.

Hoewel sociale en individuele dynamieken cruciaal zijn voor ons begrip van reproductieve navigatie, toon ik in dit proefschrift aan dat *fysieke* ervaringen ook de beslissingen van vrouwen rondom vruchtbaarheidsonderbrekingen beïnvloeden. Niet alleen bevordert of beperkt het materiële lichaam de sociale navigatie van vrouwen, maar het moet, door zijn onvoorspelbaarheid, ook *zelf* genavigeerd worden. Vrouwen moeten constant rekening houden met het brede scala aan opties, uitkomsten en obstakels dat hun (voorheen) zwangere lichaam hen presenteert. Hun pogingen om deze onvoorspelbare lichamelijkheden in lijn te brengen met hun sociale projecten – dat wil zeggen, hun pogingen om lichamelijke navigatie te onderwerpen aan hun sociale navigatie – zijn niet altijd succesvol vanwege beperkte interventiemethoden en de inherente capaciteit van het fysieke lichaam om zwanger te worden of zwangerschappen te verliezen. *Judicious opportunism* is daarom evenzeer van belang op het niveau van het lichaam als in de onzekere en onvoorspelbare sociale situaties die Gbigbil vrouwen tegenkomen in hun dagelijkse leven. Ik bepleit dat de dynamiek van reproductieve besluitvorming niet volledig kan worden begrepen wanneer deze 'lichamelijke basis' (*body basics*) niet in beschouwing wordt genomen.

In dit allesomvattende kader – dat socialiteit, individualiteit en lichamelijkheid integreert – blijken het begrip *vital conjunctures* en de inzichten over het sociale lichaam uit de Afrikanistiek relevant, maar niet voldoende. Hoewel het eerste begrip het me mogelijk maakte de details van ambigue individuele besluitvorming binnen veranderende sociale contexten te ontrafelen, en hoewel de inzichten over het sociale lichaam me hielpen te wijzen op de sociale relaties die reproductief gedrag beïnvloeden, negeren beide concepten de 'lichamelijke basis' die ten grondslag ligt aan reproductie. De alomvattende focus die ik uitwerk in dit proefschrift draagt verder bij aan kennis over reproductieve besluitvorming door de analytische dichotomieën die de huidige studies op

dit gebied domineren te overstijgen; door tegenwicht te geven aan overwegend politieke analyses van reproductief pragmatisme die het pragmatisme van het fysieke lichaam over het hoofd zien; en door kanttekeningen te plaatsen bij gangbare ideeën over reproductieve keuze en controle, die een aanzienlijk deel van het huidige publieke discours rondom reproductieve gezondheid informeren.

NOTES

PROLOGUE

[1] For the sake of confidentiality, I changed the names of all people, all lineages, and most places (except for the bigger cities of Bertoua and Bélabo) in this thesis to pseudonyms. 'Asung' – which is the word for 'village' in the local Gbigbil language – is the pseudonym of the Eastern Cameroonian village where I conducted fieldwork. I changed the name of the friend I introduce in this prologue to Celestine for several reasons. This name is not only appropriate in the local, French speaking context, but due to its 'heavenly' connotation also reflects the Christian convictions of my informant, the sad end of her life story, and the expression of her five year old daughter, who told me more than once that 'my mother lives in heaven now'. Throughout the dissertation, I have attempted to present my informants' personal stories – and the intimate, potentially harmful or humiliating details they provide – in a way that guarantees their anonymity. Personal details that could possibly lead to identification have been omitted or made unrecognizable.

[2] As will become clear in the rest of this dissertation, the word *mama* is used to indicate older women in the village – irrespective of whether they have actually borne children or not. While the bearing of children might enhance the (early) adoption of this title, Chapter 5 will show that even infertile women are eventually referred to as *mamas.* This term of address thus forms more of an acknowledgment of social status than a precise indicator of biological motherhood.

[3] Although the word *marabout* can refer to various kinds of traditional healers, my informants use it particularly for Islamic healers from the North of Cameroon, who treat both natural and spiritual afflictions through clairvoyance, incantations, mystical powders, and natural products. He or she is believed to 'see' evil powers or spirits and to be able to interact with them.

[4] Throughout the thesis, I will speak of 'tactics' rather than 'strategies' to denote women's inventive practices. This conceptual choice is inspired by the work of Michel de Certeau (1984) and will be discussed more elaborately in Chapter 5.

INTRODUCTION

[1] Of course Barth's study, which focused on secrecy in ritual and public performance, would now be labelled structural-functionalist in its approach. In line with Piot's (1993) argument, Celestine's case shows that secrecy and ambiguity are as much part of everyday life as of rituals like the ones described by Barth. Barth's claim that secrecy enshrouds high-stakes issues thus seems to apply well beyond the scope of his original research.

[2] Although the wide-ranging estimates for rates of pregnancy interruption may be due to different measuring methods and the fact that many losses occur imperceptibly, it should also be stressed that pregnancy loss concerns a biological event that is liable to local variations and frequencies. In this sense, Lock's (1993b) notion of *local biologies* is more telling than general estimates that either overlook or try to incorporate all local rates of recurrence.

[3] This demographic survey and all other methodologies used for this research will be discussed in Chapter 1. The questionnaire and statistical results are presented in Appendices V and VI.

[4] In their elaborate review of the field of the anthropology of reproduction, Ginsburg & Rapp (1991) mention that before 1960, only a few cross-cultural surveys had focused on reproductive beliefs, norms, and values. McClain (1982) has reviewed some of the more elaborate studies from that time, such as Clellan S. Ford's *Comparative Study of Human Reproduction* (1945), M.F. Ashley Montagu's *Early History of Embryology* (1949), and Robert Spencer's *Primitive Obstetrics* (1949-50).

[5] This interest was stimulated by the World Health Organization, which identified research in fertility regulation as a priority area. Its Indigenous Fertility Regulating Methods Project began as part of the Task Force on Psychosocial Research in Family Planning, which in turn was part of the Special Programme of Research, Development and Research Training in Human Reproduction. The Task Force was brought together to identify the characteristics of different methods of fertility regulation that affect their acceptance in various cross-cultural settings. The goal was to provide guidance to biomedical scientists engaged in the development of new, culturally appropriate methods (Newman, 1985).

[6] Hunt (2005, p. 432) has criticized the concept of the 'African infertility belt' for its homogenizing and reifying effects.

[7] This attention to infertility in the region was not only inspired by scientific curiosity, but certainly also by colonial interests. The 'under-development' of the East Province was attributed to its 'under-population' and its lack of labour force. The colonial regime thus aimed to achieve the development ('*mise en valeur*') of the region through population growth. This idea survived after independence, with President Ahidjo reiterating that '*sous-population*' leads to '*sous-développement*'. The implications of such ideologies for the creation of national population and health policies will be discussed in the next chapter.

[8] The 1994 International Conference on Population and Development (ICPD) in Cairo played a significant role in this paradigmatic shift. The ICPD witnessed criticism of the demographic means of calculating and attempting to manage global population, and the ascendancy of the 'reproductive health' discourse emphasizing rights and choice. Participants also gave lip service to studying aspects of culture, social and gender relations, ideological backgrounds, and economic and political conditions that influence reproductive behaviour.

[9] The growing focus on infertility and fertility problems in the last decades notwithstanding, infertility was already addressed by earlier studies, particularly concerning the Central African 'infertility belt'. In the late eighteenth century, colonial administrators were concerned with the low birth rates and high levels of childlessness that seemed to plague the region (Leonard, 2002; Romaniuk, 1961, 1967, 1968) – a politically inspired, biomedical preoccupation with infertility that only faded after decolonization when (post-) colonial pronatalist projects were gradually replaced by an international focus on 'excessive' fertility in African countries. It was only some decades later, after the ICPD with its voluntaristic rhetoric of people having 'the freedom to decide if, when and how often' (*Program of Action,* paragraph 7.2) to reproduce, and the afore-mentioned developments in the social sciences, that interest in infertility again manifested itself. Feminists and other social scientists argued that reproductive rights and choices should also pertain to infertile women, largely overlooked in international discussions and earlier normative accounts of reproduction.

[10] Recent innovations in reproductive technologies have made this process not only detectable but also visible from a very early stage; the effects of these visualizations on people's perceptions and embodiments of pregnancy, as well as on ideas about the personhood of the foetus, have been documented for different locales (Duden, 1993; Gerrits, 2008; Layne, 2003; Petchesky, 1987; Rapp, 2000; Thompson, 2005).

[11] Both Chapman (2003) and Earle *et al.* (2008) propose encompassing definitions of 'reproductive loss' as well, though they do not explicitly include induced abortions and fertility regulation practices. Nevertheless, while Chapman (2003, p. 361) states that 'the term "reproductive loss" refers to miscarriage, perinatal deaths (stillbirth to 7 days post-partum), and infant deaths (1 week post live birth to 1 year postpartum)', she *does* include rates of induced abortion in her overviews of different forms of pregnancy loss. She also acknowledges the risk of induced abortions being reported as miscarriages – and thus accounts for their possible presence within the category of reproductive loss.

[12] For work on the oppositional relationship between the normal and the pathological, see Canguilhem (1991) and Foucault (1994).

[13] To keep the argument concise, I have chosen to focus on the international health arena as a whole, without elaborating upon the internal differences or the specific biomedical and legal discourses that underlie and inform it. Biomedicine and law have their own particular debates and concerns around intended and unintended abortions, inspired by different aims and epistemologies.

[14] That the concept of reproductive health became prominent after the ICPD does not mean that no work and thinking on reproductive health had been done before this conference. As the historical overview in this introduction has shown, the 'anthropology of birth' in the 1980s and the switch of focus from function to authority in the early 1990s had already produced scholarly contributions to the development of reproductive health. Inhorn (2006) has shown how many ethnographic studies, both before and after the ICPD, have been important in this respect and should be taken into account when 'defining women's health' – something that 'has been largely forwarded by Western biomedical and public health establishments' (ibid., p. 345).

[15] Here, a leading role has been played by the Post Abortion Care Consortium, formed by VSC International (now EngenderHealth), Ipas, the International Planned Parenthood Federation (IPPF), the JHPIEGO Corporation, and Pathfinder International (Corbett & Turner, 2003).

[16] Unsafe abortions are defined by the World Health Organization (1992) as 'any procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both'.

[17] The Post Abortion Care Consortium task force expanded the original post-abortion care model in 2000 and endorsed the 'Essential Elements of Post Abortion Care' in 2002. This revised model's five elements are: community and service provider partnerships; counselling; treatment; family planning and contraceptive services; and reproductive and other health services (Corbett & Turner, 2003).

[18] In fact, there is a growing body of anthropological literature that takes the global health arena as its research subject, critically reflecting on anthropology's engagement in these debates. See, for instance, Hahn & Inhorn (2009), Janes & Corbett (2009), and Pfeiffer & Nichter (2008).

[19] As Auerbach & Figert (1995, p. 115) note, feminists do not monopolize the women's health movement. Instead, we witness several movements and perspectives that centre on 'the general health needs of women or the particular health needs of certain women'. Nevertheless, feminist scholarship over the past 30 years has been prominent in setting these movements' agendas as well as in the debates surrounding international reproductive health.

[20] These are mostly psychological studies that make use of the *Perinatal Grief Scale* (PGS), developed by Toedter, Lasker & Alhadeff (1988). Despite its misleading name, the scale is designed to measure grief following all forms of reproductive loss – covering the whole continuum from early miscarriage to neonatal death. It assesses general and specific as well as 'normal' and 'pathological' grief reactions to pregnancy loss. The original scale counted 104 Likert-type items and was reduced to a more manageable 33 items, subdivided into the categories 'active grief', 'difficulty coping', and 'despair', by Potvin, Lasker & Toedter (1989). The device has been argued to be cross-culturally applicable due to its internal and external validity (Boyd Ritsher & Neugebauer, 2002; Toedter, Lasker, & Janssen, 2001).

[21] For critical reviews of the literature on the psychological consequences of miscarriage and its follow-up care, see Frost & Condon (1996) and Lee & Slade (1996) respectively.

[22] The universality and unconditionality of this mother-infant attachment have been questioned by both anthropologists and non-anthropologists critical of the ethnocentric assumptions of maternal bonding theories (for an overview of this literature, see Adams, 1995). Rather than being natural, maternal love and women's grief in cases of reproductive interruptions are argued to be influenced by both structural conditions and cultural notions (of motherhood, of embryology, of personhood, of death, etc.). The afore-mentioned work of Scheper-Hughes (1992) and the evolutionary theory of Hrdy (1999) have been prominent in this debate.

[23] In coping theories, the distinction is often made between a first period of cognitive appraisal, followed by *problem-focused coping* (or *active behavioural coping*) and/or *emotion-focused* coping. During the primary appraisal phase, a person evaluates the situation and defines his or her stakes. When the situation is deemed threatening, this person then evaluates available coping options. Problem-focused coping is an effort to actively manage or deal with the cause of the problem, whereas emotion-focused coping takes place in situations where people do not feel in control and merely try to deal with the negative emotional consequences of a problem. Which coping strategy is used depends on the specific problem as well as on personal and contextual factors. People may use a mixture of these types of coping, and coping mechanisms will usually change over time (Koster, 2003). Coping, in being 'transactional', explicitly places people's thoughts and behaviour within wider structural forces (Folkman, Lazarus, Gruen, & DeLongis, 1986).

[24] This point of view represents just one side in a more encompassing debate on abortion and has been refined, criticized, and contested by many anti-abortionists. Nevertheless, the representation of abortion as a device for women to control their own bodies is widespread – whether or not people agree that women have a *right* to exert this autonomous power.

[25] Yet, I am also aware that the prefix 'vital' turns the concept into an unspecified, overly general one that risks ending up in conceptual hollowness, as life is full of vital conjunctures of many different sorts. To narrow the focus of this thesis and to limit the scope of my conclusions to critical moments surrounding *reproductive* events – without claiming that similar dynamics can be found in different vital conjunctures – I will henceforth speak of 'vital conjunctures around reproductive interruption' or simply 'reproductive conjunctures'.

[26] Although the term 'navigation' may suggest individualist, actor-oriented connotations, the way I use it – drawing on Vigh – explicitly aims to prevent such associations. Vigh's understanding of social navigation 'takes its point of departure in the interplay between social perspectives, actions and forces' and investigates 'how a group of agents seek to move within a complex set of societal structures' (2006, p. 11). Focusing on terrains of war in Guinea-Bissau, he argues that navigation 'is primarily a question of evaluating the movement of the social environment, one's own possibilities for moving through it, and its effects on ones [*sic*] planned and actual movement' (ibid., p. 13). Vigh thus attempts to explain the interplay between social perspectives, actions, and forces in terms of the mutual dependence of horizons in motion, agents in

motion and terrains in motion. In this sense, social navigation 'is not another metaphor for agency, but rather designates the interface between agency and social forces' (ibid., p. 14) – comparable to Johnson-Hanks' 'judicious opportunism'. By focusing on the flexible interrelationship between decision-making and structural contingencies, the notion of navigation allows us to understand how Gbigbil women manage their unforeseen reproductive conjunctures. In a more abstract sense, it touches on the question of how individuality and social embeddedness are at play in (reproductive) decision-making – a question that will be taken up in the conclusion of this dissertation.

[27] Since the body appeared as a topic of social science research and theorizing in the 1970s, many anthropologists have pointed to the inherent sociality of the body. These anthropologists – ranging from those engaging the early work of Mauss (1950) and Bourdieu (1977), through those focusing on symbolic representations of society through the body (Devisch, 1993; Douglas, 1966; Feldman-Savelsberg, 1999; Godelier, 1992; Héritier, 2003; Scheper-Hughes & Lock, 1987; Taylor, 1992), to those foregrounding phenomenological approaches of embodiment since the 1990s (Biehl, Good, & Kleinman, 2007; Csordas, 1990, 1994; M. Jackson, 1998) – have long acknowledged some interrelationship between the individual body and its social surroundings. Some have explicitly deployed the term 'social body'. Literature overviews by Lock (1993a), Csordas (1994) and van Wolputte (2004) all mention the distinctive uses of the concept by Douglas (1966), O'Neill (1985), and Scheper-Hughes and Lock (1987) respectively. Douglas distinguishes the social body from the natural body, where the former forms a framework to interpret and represent the latter – a distinction which thus reproduces, according to Csordas (1994, p. 5), dualistic oppositions between mind and body, or culture and biology. For O'Neill, who designates five bodies, the social body refers to the analogy of social institutions to bodily organs, as well as to the use of bodily processes such as ingestion of food to define social categories. Finally, alongside the individual body and the body politic, Scheper-Hughes and Lock recognize a social body, to the extent that it is used as a symbol of nature, society, and culture. More recently, Lambert and McDonald (2009, p. 10) have proposed an interpretation of the 'social body' that falls beyond any of these approaches. They draw attention to the inherent sociality of fragmented and 'disembodied' body parts when they state that 'bodies exist only where there are relationships; personhood and relatedness (or social substance) emerge as being essential to the "bodiliness" of human material. Bodies do not express, incorporate or embody the social. Rather, they *are* inherently social'.

[28] A recent body of work questions the dichotomy between a Western ego-centric 'individual' and a non-Western socio-centric 'dividual' (Carsten, 2000, 2004; Halliburton, 2002; LiPuma, 1998; Sökefeld, 1999; Spiro, 1993) and is reluctant to interpret the distinction between individualistic and socio-centric notions of bodies and personhood in terms of Western and non-Western. Instead, it has been argued that both aspects are present in persons all over the world, but become variously dominant in different cultures or contexts.

[29] In his review of Johnson-Hanks' book in *Social Anthropology*, Martin Slama argues that the author's approach is mainly demographic, with statistics forming the most interesting contribution of the study; in-depth anthropological analysis is lacking. He notes that, 'l'approche anthropologique est difficile à détecter. (…) Le corpus des interviews formelles (14 collectées par l'auteure, 149 par ses assistants) se noie dans des descriptions parfois génériques et répétitives. En particulier, le contexte dans lequel mûrissent ce que Johnson-Hanks considère comme les 'circonstances-charnière' ('vital conjunctures') des étudiantes beti se limite à un arrière-plan d'où ne se dégage aucune analyse de référence (rapports inter-générationnels, insertion professionnelle des jeunes par rapport à la conjoncture économique, sexualité sous influence, etc.) à même de justifier véritablement le titre de la maquette' (2007, p. 394).

[30] Methodologically, this means that I will retrospectively take into account the life histories of my informants, and prospectively follow them through their reproductive conjunctures. As such, I also address Guyer's more elaborate critique of the retrospective approach taken by Johnson-Hanks. In addressing the shortcomings of her study, the latter has acknowledged this retrospective bias and admitted that 'a better approach would be to interview women about their reproductive intentions, expectations, and aspirations before they became pregnant, and then to follow them forward through time' (2006, p. 198). This is what the current study aims to do; it focuses on women's projects and how these are (individually or socially) constituted and change over time.

CHAPTER 1

[1] See Appendix I for geographical maps of the country.

[2] A census conducted in 2005 by the then residing doctor of the *Centre de Santé Intégré* identified 1,084 inhabitants in Asung. A report by the municipality of Bélabo two years later (Sous-préfecture de Bélabo, 2007, p. 3) reported a total of 1,007 village residents, of which 461 men and 546 women.

[3] Indeed, an ongoing process of migration from probably the 1500s onwards has been noted for several ethnic groups in the region (Billard, 1961; Copet-Rougier, 1987; Johnson-Hanks, 2006; Laburthe-Tolra, 1981; Nelson et al., 1974). Most of them would have been driven into the area during wars with the expanding Fulani groups to the north of the Sanaga river. A legend shared by different ethnic groups relates how they had been saved in the heat of the war by a big snake transforming itself into an enormous trunk of a tree, connecting both shores of the Sanaga river and thus enabling the forest people to cross the river (Bokally, 2003; Laburthe-Tolra, 1981; Onambele, 1995). Dugast (1949) states, however, that this was not true for the Gbigbil people; they would rather be relatively autochthonous to the region. The same is noted in a historical document written by an inhabitant of Asung; he states that Gbigbil are in fact related to the Ba-Yoka of Congo, who emigrated southwards in the 16th and 17th centuries – and have ever since lived in the south-eastern part of Cameroon. The speculations of my Gbigbil informants about their origins were multiple, but also tended to locate their roots in the region around Yaoundé or elsewhere in the south, rather than the north.

[4] Mengue (1982) indicates that the Gbigbil population decreased with a rate of -2.5% between the years 1935 and 1967, starting from a number of 6,578 in 1935. From 1967 onwards, the growth rate increased again to 1.7%, leading to a total Gbigbil population of 5,357 people in 1976.

[5] Mengue (1982, p. 101) explicitly mentions malaria, leprosy, syphilis, and gonorrhoea as major endemic illnesses in the region. Billard (1961) adds the immense problem of sleeping sickness (*trypanosomiasis*) which was largely eliminated by Doctor Jamot, who developed a prophylaxis against the disease in 1917 (Leh, 1987, p. 90).

[6] Abega (2007) claims that this massive relocation has had a major impact on sexual and marital practices in the new villages. Contrary to what had happened before, sexual partners were no longer to be found *outside of* the village – formerly strictly composed of blood relatives – but could now be selected from other lineages that inhabited the same village. This, according to Abega, led to decreased control of elders over youngsters, and thereby to a weaker adherence to marital rules and sexual interdictions.

[7] One *sous-chef* once told me that the terrain of the village has been divided in a rather disordered way due to three major reasons. First, there was *désordre* because of the conflicts between brothers at the moment of division, which led to settlements such as Bitamien at some distance from the main group. Second, the uneven and retarded departures from the *ancien village* meant that some latecomers, upon their arrival in Asung, found that all the terrain allotted to their lineage had already been occupied by their family members. They had to search for non-allotted terrain or settle within another lineage. Third, those who resided in cities at the moment of the migration would come back to build a house in Asung, but would either find the terrain occupied or prefer terrain of better quality in other areas around the village. Such a case led to the settlement of Akepa, which was founded by a returned city-dweller and some of his followers.

[8] It should be noted that during my last fieldwork period in 2009, a qualified nurse was appointed who seemed very eager to improve people's well-being in general and pregnant women's access to the health centre in particular. This *dokta*, as people called him, was still present in the village when I finished writing this dissertation in 2011.

[9] It concerns a missionary station that had already been built in the 1930s in the *ancien village* of Kamandjom, and was transplanted along the paved road in 1967. The Italian and Brazilian sisters that are currently present are part of the *Délégation Sainte Catherine de Sienne* of the congregation of *Sœurs Dominicaines de la Bienheureuse Imelda,* which consists of ten members: four Italian, four Brazilian, and two Cameroonian sisters. The delegation is installed in Bertoua, Kamandjom, and Yaoundé. It particularly aims at educating children and youngsters (Bauvineau, 2004; Ngo Baleba, 2003).

[10] Among the information booklets offered in the waiting room, I only found one folder on puberty and sexual behaviour (titled '*Éducation à la vie et à l'amour. Reussir sa puberté*'). Unwanted pregnancies, induced abortions, and family planning methods are mentioned, but in overtly negative tones – with a focus on irresponsibility, risks, and disorder. The booklet calls for sexual responsibility and consciousness, against the background of divine judgment and advice. This official Christian discourse and health policy notwithstanding, one of the local nurses who originated from the village of Kamandjom told me that he informally sells contraceptives at home.

[11] Mengue (1982: 162) mentions the dates of permanent installation in the East of Cameroon of 1939 for the Catholic mission and 1949 for the Presbyterians and the Seventh Day Adventists.

[12] People in Asung state that within the occult world of *mgbəl*, there are actually several forms of witchcraft – of which *ivū* is the most important one. As in the narratives of the informants of Vincent (2001) and Mallart Guimera (1981), my Gbigbil friends expressed contradicting views on the character, origins, and development of *ivū.* Many believed it to be an essentially female form of witchcraft. Myths about *ivū*'s

origins relate not only why this power is inherently related to women, but also why it 'always has a negative tone' – as a male informant confided to me. He traced the history of *ivū* as follows: '*Ivū* was a woman who lived in the forest, very beautiful. She didn't eat leaves, but only loved to devour flesh and suck blood. A man from the village encountered this woman during his hunting trips. After a certain time, he asked her whether she would be willing to marry him, because he found her so beautiful. The woman asked him, 'Are you sure you can endure my character?' The man replied, 'You are beautiful, I will always endure you'. The woman gave him her condition: she only wanted to eat meat and blood; no leaves. The man thought about his sheep and goats at home, accepted the condition, and took her to the village. There, she started to eat all animals: goats, chicken, cows, everything! When the man was not able to satisfy her anymore, she was prone to kill in order to have her flesh. This is a how *ivū* came to the village and started to ravage here. The man already regretted his decision, and that's how it is for us men in general: you can take a woman into your house, but you never know where it will bring you'. Variations of this tale relate how *ivū* was not a woman herself, but rather a creature from the forest brought into the village by a woman – as a crab that entered her vagina during fishing, or as a dangerous predator that she encountered on her way to the fields. Either way, what underlies all these accounts is a common plot of a destructive power brought from the forest into the village through a *woman.* This inherent link of *ivū* to the female realm is especially relevant in matters and accusations related to fertility, as we will see in the chapters that follow.

[13] The disengagement and mismanagement of the state, the adoption of Structural Adjustment Programs in 1988/89, the devaluation of raw materials on the international market, and the commercialization of input products had all led to higher costs and lower incomes for Cameroonian farmers. Consequently, the production of coffee decreased from 110,000 tons to 75,000 tons a year and cocoa production diminished from a yearly 200,000 tons to 120,000 tons (Konings, 1995; Moupou & Akei Mbanga, 2008). Nevertheless, interest in those products might be revived in the near future. An announcement in the daily *Cameroon Tribune* stated on 5 May 2009 that, after fourteen years of withdrawal, the Cameroonian government had reinstalled some subsidies for coffee and cocoa investments. Several villagers also confirmed to me that it became more and more attractive to them to put some effort again into the production of coffee and cocoa.

[14] The protests were a series of violent demonstrations in Cameroon's biggest cities from February 25 to 29 that year. The protests followed a strike by transport workers, who were opposing high fuel prices and poor working conditions. Further unrest resulted in response to the generally high cost of living in Cameroon, high unemployment among youths, and President Paul Biya's proposal that the constitution be amended to abolish term limits on the presidency and allow him to run in the 2011 elections. Biya has been president of Cameroon since 1982. The official government account states that 40 people were killed during the riots, but human rights groups claim that the total must be closer to 100 (see further http://en.wikipedia.org/wiki/2008_Cameroonian_anti-government_protests).

[15] PLAN International has been working in Cameroon since 1996 and is currently active in 11 rural zones in three departments of the East Province of Cameroon: Haut Nyong, Lom et Djerem, and Kadei (personal communication, 21-01-2008). Over time, PLAN has constructed a primary school (in 2003) and a kindergarten (in 2008) in Asung, built wells for quick access to safe water, connected deprived children (103 in 2008) to foster parents in the Western world, trained traditional midwives, financed medical interventions (such as vaccinations and elements of mother and child health care through its '*Projet de survie de l'enfant à Impact Elargi*' (EIP)), organized informative gatherings on health and social issues, and subsidized two women's associations: *Sol ngon* and *Seying ining* between 2000 and 2004. See Chapter 5 (endnote 2) for more information about the particular activities of these women's associations in the village of Asung.

[16] This Gbigbil language is part of the Yaoundé-Fang group of languages and falls within Guthrie's linguistic classification A73b (Guthrie, 1953, p. 40).

[17] This linguistic diversity is, however, not at all exceptional in Cameroon; more than 200 ethnicities and languages have been reported to exist in the country (Grimes, 1988; Kamla, 1992; SIL International, 2001).

[18] Now that these extended families are forced to live together in one village context, the family elders of these lineages have become political *sous-chefs*. On top of these sous-chefs is the *chef du village*, an old man who had occupied this position since 1977 (although officially nominated only in 1994; Sous-préfecture de Bélabo, 2007, p. 6) and lives on a small hill in the centre of the village. His status is utterly ambiguous: representing the colonial past and current (failing) state, but at the same time being a family elder of the Bibakung lineage, his actions and expressions are liable to contestation and multiple interpretations. His particular position is even more precarious since it was his brother who was originally chosen to become the chief. The current chief is therefore not properly initiated in traditional chiefdom and thus less

respected than his brother, who *does* have the required traditional knowledge (for protection of the *chefferie,* etc.).

[19] *Isam* used to be an important nightly rite invoking a 'spirit of the forest' (*tīt isam*; 'the animal of *isam*') in cases of misfortune, death, or transgression – e.g., incest, adultery, or burial of two persons in the same grave. Initiated men (*ngondj*) would assemble in the forest and light a huge fire, which was not supposed to be seen by women – who, consequently, would lock themselves in their houses at moments of *isam* gatherings. Men would sing, dance, and eat around the fire and wait for the spirit of the forest to announce itself. With a loud voice, which would even be heard in the village but not understood by non-initiates, the spirit would then denounce transgressions, indicate those culpable, require offerings for restoration of order, and teach about common norms and values. Although there are still some initiates in the village, actual gatherings of *isam* are rare nowadays. Ever since authorities have come to associate the practice with destructive witchcraft activities, the village chief has forbidden *isam*. Similar traditions have been described by Laburthe-Tolra (1981) and Mengue (1982) as *esam* and *sam* respectively.

[20] This ambivalence is especially shown at the moment of the death of a married woman. In the absence of any marriage certificate or completed bride-price transactions, not only their place of burial becomes contested, but also their value to the respective families. In most cases, the woman's own family members will require the corpse of their daughter, as well as a belated bride-price ('*doter le corps*'), in order to compensate for the 'time she has lost' in a long marriage and for the children she had borne for her husband's patrilineage. This transportation of women's corpses to their families shows that, regardless of length of marriage or number of children, they always remain outsiders in the lineage of their husbands – a point that is moreover playfully but dramatically denounced by in-married daughters-in-law (*ngamon*) during their mourning rituals, transgressions, and exclamations (see, for instance, the epigraph to Chapter 3).

[21] Although juridical provisions in the Cameroonian legislation have first fixed a maximum amount of the bride-price, and afterwards prohibited the practice altogether, they remain without effect in reality (Velghe-Scherpereel & van de Wouwer-Leunda, 1996, p. 26). Indeed, even if people are not able to pay or receive all parts of the bride-price in practice, the reciprocal *framework* continues to pervade their expectations, and contestations, of marriage.

[22] In former times this presentation of the self as a possible marriage partner to somebody else's daughter – or inversely, the promise of one's daughter to a powerful alliance partner – would often happen without both marriage partners really knowing each other. Rather, marriage would largely be concluded on the initiative of male elders trying to create as many strategic alliances and followers as possible (which makes sense within the 'wealth in people' paradigm mentioned on page 32). Future marriages would even be concluded while the daughter was still a little girl. In these cases, she would be sent to live with and raised by her future family-in-law for extended periods of time and then permanently install herself there at the onset of menstruation. This happened especially in pre-colonial and colonial times, when long distance trade and colonial taxes created economic hierarchies in the villages. Wealthy men had a stronger position in marriage arrangements than the poorer ones – with the latter often offering their daughters as marriage candidates to the former in order to settle debts or dependencies, or simply to acquire some wealth in the economically competitive setting (Abega, 2007). Nowadays, these 'child marriages' are completely absent in the region, although the average age at first marriage in the East of Cameroon is still among the lowest in the country (Essoh, 1991; Tinga, 1991). Furthermore, *aza leeta njol* is now only initiated when both partners have already known each other, or even only when a pregnancy exposes their previously hidden relationship.

[23] A joking relationship has been defined by Radcliffe-Brown (1940, p. 195) as 'a relation between two persons in which one is by custom permitted, and in some instances required, to tease or make fun of the other, who in turn is required to take no offence'. It is a particular manifestation of friendliness and hostility, of joking and avoidance, at the same time. This relationship of 'permitted disrespect' (Radcliffe-Brown, 1940, p. 196) has been noted to be particularly present among relatives by marriage in Africa, and functions to alleviate the tensions that possibly underlie the marital relationship. In the Gbigbil case, joking relationships exist especially between in-laws and their sons-in-law or daughters-in-law, and between mother's brother (*ngweej*) and sister's child (*mo kal*).

[24] *Kanako* is not a Gbigbil word but is thought by villagers to originate from the semi-Sudanese Gbaya language in the surroundings of Batouri and the borders with the Central African Republic more eastwards. Indeed, its use has been reported for the Mkako people in Batouri by Notermans (1999) as well. With regard to the Gbigbil version of *kanako,* one informant stated: 'In former times, the Gbigbil knew a tradition that is similar to the current *kanako.* We call it *kita kita.* Whenever a girl would leave into her marriage, her new parents-in-law would offer an animal to her parents in order to recognize that their daughter is already

living with them now'. However, *kanako* nowadays comprises more than only an animal; besides two goats or two sheep, people talk about the essential gifts of two knives (with which the animal will be killed), two bags of salt (with which the animal meat will be prepared), two *dame jeannes* of wine, two bottles of whisky, two *casiers* of beer, and two glasses (with which the drinks will be consumed).

[25] Abega (2007, p. 111) has noted that despite the decrease in *frequency* of bride-price transactions, the actual *amount* of money transferred has augmented over time. According to the World Bank, the national income per capita in Cameroon in 2009 was 573,372 CFA Francs (around 873 Euros) per year, or a monthly 47,781 CFA Francs (around 73 Euros) (see http://data.worldbank.org/ country/cameroon). The sum of money currently paid for a bride-price is thus the equivalent of two months' income – which, for villagers without a regular source of revenues, means a considerable strain on their daily budgets.

[26] In practice, though, this *acte de mariage* can also be signed before the bride-price has been paid in its totality. In an insecure marriage setting where 'traditional' payments are often lacking, women and their families might seize upon an offer for formal marriage, or even enforce it themselves, before bride-price transactions have been completed. Mama Rosie's story in Chapter 5 provides an example of this.

[27] Some legislative changes do, however, aim to improve the situation, and inheritance rights, of widows. They stipulate: a consideration of the surviving spouse in the inheritance of the deceased spouse if the latter does not leave a direct heir, nor bastard children, nor family members in the rank of successor; a modification of the possibility to claim a husband's pension after his decease (before 1994, women could only obtain 50% of it for minor children); an acknowledgement of the right of a widow or divorced woman to ask for the division of the community of goods, and the obligation for a called-upon judge to command so; and an acknowledgement of the right of a widow to be appointed as administrator of goods while inheriting children are still minor. Drawbacks are, however, that women only have usufructuary rights on the property that will eventually belong to their children, that they have difficulties to effectively administer these goods in practice due to familial pressure and other social factors, and that the division of goods is especially problematic in polygynous marriages, which are not acknowledged by the French civil code (Velghe-Scherpereel & van de Wouwer-Leunda, 1996, p. 63).

[28] Yet, other dynamics seem at play here as well. Abega (2007, p. 112) points for instance towards a certain unwillingness of some women's family members to receive a bride-price these days. In the light of current marital instability, they fear an eventual separation of their daughter with a partner who has already initiated bride-price transactions. In this case, the woman's family members would be obliged to return all the received gifts. This often leads to problematic situations when they have immediately consumed the goods and spent the money that they received. To prevent such problems, family members prefer to let some time pass and ensure themselves of the stability of the relationship before they are willing to accept any gifts or money from possible sons-in-law.

[29] According to article 361 of the Cameroonian penal law, adultery of a married woman consists of her having sexual intercourse with any other man than her husband, while a man is perceived to be adulterous only when he has sexual intercourse in the marital home with other women than his wife or wives, or when he has regular sexual intercourse with another woman outside of the marital home. Velghe-Scherpereel & van de Wouwer-Leuda (1996, p. 64) note that this definition makes it difficult to effectively establish the adultery of men.

[30] I prefer to speak of kinship as an 'idiom' rather than a 'system' because it stresses the negotiability and situationality of kinship norms and the way they are strategically used. A kinship idiom offers certain norms and categories, but these are liable to different interpretations and applications to very divergent situations and persons (cf. Geschiere, 1982). This makes kinship more a social phenomenon and cultural enterprise of relatedness than a biological affair of mere procreation. Such a flexible view on kinship matters is also prevalent in the 'new kinship studies' in anthropology that react against the biological essentialism of former studies on the subject (Carsten, 2004; Franklin & McKinnon, 2000; Holy, 1996; Strathern, 1995).

[31] Total packages consisting of baby clothes and products – called 'bébé chéri' – can be bought at the local market for 7,500 CFA Francs (around 11 Euros).

[32] Cameroon's socio-economic development after independence can be subdivided into three successive phases: a first period of economic growth between 1970/71 and 1978/79 due to public investments in the agricultural and industrial sectors; a second period of exponential economic growth between 1978/79 and 1984/85 due to a boom in petrol exportation; and a (still continuing) era of economic decline from 1985/86 onwards due to the decreased value of Cameroon's export products of petrol, cocoa, coffee, and cotton on the world market, and the subsequent devaluation of the CFA Franc in 1994. This economic decline was accompanied by a greater dependence on international agencies and a disengagement of the state with regard to its national policies and production system (Kamdoum, 1994a; Moupou & Akei Mbanga, 2008).

[33] Leh (1987) mentions that the expenditures on health-related issues increased from 12.2% of the total budget in 1940 to 24.6% in 1945.

[34] Even before this era, however, mobile sanitary equipments had been formed under the 'Strategy Jamot' from 1926 onwards. Three types of medical interventions were envisaged by these groups of itinerant medical staff: treatment of patients, protection of healthy subjects, and the fight against epidemics (especially sleeping sickness). These interventions form the very foundation of public health in Cameroon – called '*medicine sociale*' at that time – in which health came to be promoted and protected (Atangana, 1998).

[35] However, from 1968 onwards, some efforts were made to improve the national coverage of health services through the installation of six DASP zones (*zones de Démonstration d'Action en Santé Publique*), where experiments with rural preventive health care were undertaken. These initiatives were financially supported by the World Health Organization and UNICEF. Itinerant health personnel undertook several activities in the five kilometres surrounding health centres: home visits, medical screening, treatment of leprosy and tuberculosis, health education, and the distribution of medicines. An evaluation of the experiments in 1975 concluded that local communities expressed a strong demand for health care, were willing to participate in the financing and organization of sanitary activities, and would be able to create village pharmacies. A major drawback of the project was, however, the inappropriate training of itinerant health personnel. Due to the high costs and the lack of coordination with other interventions of the Ministry of Health, the DASP zones were finally abandoned in the mid-1970s (Atangana, 1998; Ministère de la Santé Publique Cameroun, n.d.; Van der Geest, 1982b).

[36] More specifically, the 150 governments participating in the Alma Ata conference agreed that all the inhabitants of their respective countries must attain a level of health which would allow them to live socially and economically productive lives. Health in this case did not merely mean the absence of illness or infirmity, but was defined as 'a state of complete physical, mental, and social well-being'. Four constituting components were defined that would have to be taken into account when aiming for 'health for all': external agents (such as infectious diseases), heredity, environment, and behaviour. The governments concluded that a public health approach should take the entire population rather than the individual as a starting point (Ministère de la Santé Publique Cameroun, n.d.).

[37] Despite some similarities of the proposed primary health care approach with the existing health care system, Atangana (1998) notes that the adoption of the new health strategy was far from easy in Cameroon. The Ministry of Health had to launch radio campaigns, sensitize its provincial delegations, and seek cooperation from administrative authorities in order to make the new approach accepted and implemented at different levels. These efforts of the Ministry of Health have resulted in the 'Methodological essay for the management of primary health care in a community' ('*Essai de méthodologie pour la mise en oeuvre des soins de santé primaires dans une communauté*'). Finally, community health agents (*agents de santé communautaire*), health villages (*villages-santé*), and village health committees (*comités villageois de santé*) were installed after the Alma Ata Conference.

[38] This primary health care approach was organized around eight essential components: 1) health education; 2) promotion of correct alimentation and nutrition; 3) mother and child health; 4) vaccination against important infectious diseases; 5) sufficient supply of healthy water; 6) prevention and control of local endemic diseases; 7) appropriate treatment of current diseases and traumas; and 8) supply of essential medicines. The primary health care approach had to be an *intersectorial* approach in which all these components were considered indispensable to contribute to better health (Atangana, 1998; Ministère de la Santé Publique Cameroun, n.d.).

[39] Owona Essomba *et al.* (1993) note that the national budget dropped from 800 billion CFA Francs in 1987/88 to 572 billion CFA Francs in 1991/92. Along with these economic declines, the percentage of the government budget allocated to the Ministry of Health dropped from 5.2% in 1989 to 4.4% in 1991, while the per capita health expenditure dropped from 3,971 CFA Francs in 1985 to 2,060 CFA Francs in 1992.

[40] More specifically, these problems had to do with the continuity, integration, inclusiveness, and consistency of care; the sustainability and acceptability of the system at the community level; the overload, devaluation, and lack of training of the mediating community health committee members; and the absence of political support and juridical frameworks encouraging and supervising this system and its envisaged community participation (Eto, 2005; Ministère de la Santé Publique Cameroun, 1999; Owona Essomba et al., 1993; Van der Geest, 1982b).

[41] This conference stressed the importance of community-based health activities for the reinforcement of health systems. Health development interventions would have to be perceptible on the peripheral, intermediate, and central levels (Ministère de la Santé Publique Cameroun, n.d.).

[42] In order to attain the goal of 'health for all by the year 2000', this conference recommended the adoption of a health system based on decentralized districts (Ministère de la Santé Publique Cameroun, n.d.).
[43] Medicines would from now on discontinue being free of charge and being supplied by the Central Pharmacy. Rather, in 1985 a Pharmaceutical Office (ONAPHARM) was created that would supply local pro-pharmacies with essential drugs. But, as Kamdoum (1994b) has noted, the lack of national pharmaceutical policies and the absence of a formal list of essential medicaments have considerably retarded the installation of an efficient system of medical supply and sale. ONAPHARM was dissolved in 1995 and with the assistance of the German *Gesellschaft für Technische Zusammenarbeit* (GTZ) and the European Union, a new structure called the National Clearing House for Essential Drugs was created (Wankah, Ndongo, & Abega, 1998).
[44] This reorganization was not only meant to facilitate the incorporation of the new aims and strategies, but was also deemed to diminish the overlap of responsibilities of different former directorates. A Department of Community Health and a Department of Human Resources were created, and the divisional health service level was suppressed in favour of health districts that were supposed to correspond to administrative subdivisions – which in practice they did not always do (Wankah et al., 1998).
[45] The central level is charged with the formulation of health policies and comprises the Ministry of Public Health, health-related research institutes, as well as three General Hospitals and three Central Hospitals. The intermediate level consists of ten Provincial Delegations, their respective Provincial Hospitals, a Special Fund for Health Promotion (*FSPS: Fond Spéciale pour la Promotion de la Santé*), and a drug supply centre (*CAPP: Centre d'Approvisionnement Pharmaceutique Provincial*). It also has the responsibility to provide technical assistance to the peripheral level. This latter level includes all Integrated Health Centres, offering basic health care, as well as District Hospitals, offering secondary services.
[46] This 'minimal package of activities' which is to be offered by all health facilities at the peripheral level comprises maternal and child care, curative care, treatment of chronic diseases, prevention, surveillance and control of endemo-epidemics, supply of essential drugs, referral and counter referral, and health promotion (information, education, and communication) activities (Ministère de la Santé Publique Cameroun, 1993d, 1999).
[47] The most important laws are the 1992 Declaration of a Sectorial Health Policy (revised in 2001), the 1993 National Declaration of the Implementation of the Reorientation of Primary Health Care, and the 1996 National Health Policy (n° 96/3 of 4 January 1996). Further, several other laws have been formulated that enhanced the implementation of the reorientation of primary health care: the 1990 law on the freedom of association; the 1990 law permitting the sale of essential drugs; the 1995 decree on the organization of health services on the basis of health districts (n° 95/013 of 7 February 1995); the 1995 decree on the reorganization of the health system into central, intermediate, and peripheral levels; the 1997 convention on the creation of CENAME for drug supply; and the 1998 decree fixing the creation of structures of dialogue and community participation in health districts (Legba, 1998; Médard, 2001).
[48] The implication was not only that the salaries of existing health personnel were drastically reduced – with health personnel receiving in 1994 for instance only half the amount of money they had formerly earned – but also that training centres for new health personnel were closed. Thus, whereas until 1988 a growing body of health personnel was able to reduce the number of dependent inhabitants per doctor or nurse in the country, after the Structural Adjustment Programs the demographic charge for health personnel stagnated or even increased again – which subsequently led to a deterioration of the health status of the inhabitants (Kamdoum, 1994b).
[49] The Health Sector Strategy, which was launched in 2002, aims to reduce by one third the morbidity and mortality of the most vulnerable groups; to improve geographic access to sanitary structures offering the 'minimum package of care' (PMA); and to strengthen management and efficiency at all levels of the health system (Médard, 2001; Okalla & Le Vigouroux, 2001). The strategy was updated when a mid-term evaluation showed continuing challenges and failures. The revised strategy explicitly focuses on three points of attention: 1) strengthening delivery of health services through improvements in infrastructure, drug supply system, and human resources; 2) decentralizing care and enhancing autonomy and management of districts; and 3) strengthening normative functions (e.g., policy, regulation, supervision, coordination, financing, monitoring, and evaluation). The revised strategy is the basis on which all health districts have developed their 2009-2012 plans (Moupou & Akei Mbanga, 2008).
[50] The private sector is largely dominated by the confessionals (95%). In 2001, the Catholic Health Service had 190 establishments, among which eight hospitals with a total of 1,315 employees. The department of health of FEMEC, a federation of eleven protestant churches and missions in Cameroon, has 163 health institutions, of which 28 are hospitals. Of the 2,683 staff members that work in these institutions, 78 are

physicians and 90 expatriates. While these confessionals – as well as some NGOs – might pay the salaries of their health personnel, it is international donors that mostly contribute in the domains of health infrastructure, equipment, training, and the supply of essential drugs and vaccinations. International aid received in 1996 accounted for 66% of total public health spending (Médard, 2001; Ministère de la Santé Publique Cameroun, n.d.; Tantchou & Wilson, 2000). Currently, the most important international donors are: the World Health Organization (WHO), United Nations Development Program (UNDP), the World Bank (WB), United States Agency for International Development (USAID), Family Health International (FHI), United Nations Population Fund (UNFPA), the German Cooperation Agency (GTZ), the European Union (EU), and United Nations Children's Fund (UNICEF) (see UNICEF Cameroun, 2003).

[51] In this thesis, I prefer to speak of 'indigenous' rather than 'traditional' healers. I do so not only to prevent the static, much criticized dichotomy between tradition and modernity, but also to reflect the vocabulary deployed by Gbigbil people when talking about these healers – who are told to offer treatment '*à l'indigène*'. In comparing these local healing methods with biomedical health services, my informants speak in terms of 'indigenous' versus 'hospital' medicine, or 'black' versus 'white' medicine, and much less so in terms of 'traditional' versus 'modern' medicine. In the East Province, 804 indigenous healers (with various specializations) are officially registered at the '*Association pour la promotion de la médicine traditionnelle du Cameroun*'.

[52] This happens despite a 1996 decree of the Ministry of Public Health and the Ministry of Industrial and Commercial Development which formally prohibits the sale of drugs and other pharmaceutical products on the market or on the street (Kamtcha, 2004).

[53] This point is increasingly recognized by formal authorities. Under presidents Ahidjo and Biya, several five year development plans aimed at the integration of popular medicine into national health policy. The WHO's explicit aim to acknowledge and integrate traditional medicine in public health structures led to the formation of a National Committee of Traditional Medicine and an Institute of Medical Research and Study of Medicinal Plants in Cameroon in 1976. The latest law revision on 19 August 2002 provides for a service of traditional health care under the direction of the governmental primary health care (Maynard, 2004).

[54] These are in descending order: three General Hospitals, three Central Hospitals, ten Provincial Hospitals, and 136 District Hospitals, Sub-Divisional Medical Centres, and Integrated Health Centres. In addition there are mission hospitals and private clinics and hospitals (Ako, Fokoua, Sinou, & Leke, 2003; Tantchou & Wilson, 2000).

[55] This exploitation of the territory and development of the workforce were realized through the instauration of *Zones d'Action Prioritaires Intégrées* (ZAPI), financed by the World Bank. Several projects aimed at the training of youngsters in the domains of agriculture and community development, after which they were sent to the so-called under-populated zones which were to be developed ('*mise en valeur*') (Geschiere, 1982; Ngo Bell, 1990). In the same vein, traditional midwives were massively trained in Doumé. The fact that they attended 85 to 90% of all deliveries in the province was believed to underlie the high infant and maternal mortality rates. The trainings aimed to enhance both the quality of care of these midwives and their integration within existing health care services. After three years, the project showed reduced mortality rates, a lower incidence of tetanus in newborn babies, as well as more referrals of difficult deliveries to the hospital (Atangana, 1998).

[56] These indirect incentives for demographic growth consisted of monthly family allowances of 1,500 CFA Francs per child, prenatal allowances of 9,000 CFA Francs, and maternity allowances of 12,000 CFA Francs (if the pregnancy could be medically indicated), as well as the reimbursement of one month of salary during maternity leave. Further, taxes would be progressively reduced if you were married and had children. Benefits would increase until the sixth child (Ngo Bell, 1990).

[57] The law prohibiting the sale and publicity of contraceptives is n° 29/69 of 20 May 1969, based on a 1920 French law. The regulations with regard to abortion and infanticide are fixed in the articles 337 to 340 of the penal law, and will be discussed later in this chapter.

[58] Negative international preoccupation with population started already after World War II, when nationalist movements in colonized states, struggling for independence, could flourish because of population growth in these areas. From the end of the 1960s onwards, however, environmental concerns dominated the population debate, inspired by Ehrlich's *The population bomb* (1968), the Brundtland report (1987), and *The population explosion* by Ehrlich and Ehrlich (1990). Later, with changes in the international population debates and the development of Structural Adjustment Policies, unrestricted population growth also came to be seen as an impediment to socio-economic development. Policies were formulated that incorporated growth-control into the overall development scheme (Brand, 2001; Buse, Drager, Fustukian, & Lee, 2002).

[59] Sala-Diakanda (2000) notes further that in an evaluation amongst the participating countries of the conference in Bucharest, Cameroon was one of the three countries that had considered its level of fertility to be too low. Indeed, it was Cameroon's 'under-populated' situation which 'justified its pronatalist policy' (Feldman-Savelsberg, 2002).

[60] Law n° 81/10 of 14 July 1980 authorizes the sale of estrogenic contraceptives, but not of condoms. The latter could only be obtained with a medical prescription. In 1990, a new law was created that allowed pharmacists to dispense contraceptives (Ngo Bell, 1990; Tantchou & Wilson, 2000).

[61] The National Population Commission was set up in March 1985 by Presidential Decree n° 85/275. It was entrusted with the following responsibilities: to give advice on the population policy; to propose appropriate solutions for a better coordination of demographic activities and to periodically conduct an evaluation of the main results obtained; to harmonize the activities of associations or organizations likely to influence the government's population policy; and to ensure the integration of demographic factors in the conception and implementation of policies aimed at promoting economic, social, and cultural development (Commission Nationale de la Population Cameroun, 1993). However, Feldman-Savelsberg (2002, p. 222) notes that this commission met only once in 1985 and emphasized birth spacing rather than population control as the road to better health and development – which indicates the sharp contrast between the Cameroonian population policy and the recommendations of international organizations.

[62] The policy does, however, cover more issues than only population growth. Its general objectives are: 1) to improve the health condition of the population in general and that of mother and child in particular; 2) to strengthen food self-sufficiency and promote food security; 3) to promote basic education for all, and especially for girls; 4) to develop and promote qualified human resources while seeking compatibility between training and employment; 5) to develop and promote the well-being of families and couples; 6) to ensure and promote an integrated and harmonious development of cities and the countryside while preserving the environment; and 7) to promote research in the field of population. These general objectives are subdivided in 37 specific objectives, among which figure the fight against infertility as well as maternal and child mortality, the stimulation of primary health care and family planning services, education of the population on reproductive health matters, and the promotion of responsible parenthood (Commission Nationale de la Population Cameroun, 1993).

[63] This integration is regulated by the *Maternal and Child Health Care and Family Planning Policies and Standards,* which elaborates on the components of preconceptional, antenatal, intrapartum, postpartum, juvenile, and adolescent health care (Ministère de la Santé Publique Cameroun, 1993c).

[64] In July 1993, a national seminar was held in Limbé on the integration of mother and child health activities in primary health care. The participants observed that the degree of integration was unsatisfactory and proposed a strategic framework for improvement (Velghe-Scherpereel & van de Wouwer-Leunda, 1996, p. 117).

[65] Nevertheless, Nsoa Mbondo concludes on the basis of an evaluative report of the UNFPA in 2007 that only 5% of the health facilities in Cameroon are able to offer minimal reproductive health services and efficient *soins obstétricaux d'urgence* at all levels. In order to accelerate the realization of the Millennium Development Goals, the Cameroonian government is, since 2006, guided by a 'consignment note' (*feuille de route*) proposed by the African Union. It aims to circumvent the different defeats observed during the last three decennia (Nsoa Mbondo, 2008, p. 23).

[66] As it was estimated by the Ministry of Health of Cameroon that one in every fourteen Cameroonians had been affected by the AIDS virus in 2000, and as the World Bank reported that 240,000 children had been orphaned by HIV/AIDS in Cameroon in 2004, family planning and AIDS combating programs are currently abundant in the country. An important consequence of the PPTE membership of Cameroon was the adoption of the *Programme Multisectoriel de Lutte contre le Sida* (PMLS) in 2000-2001, operationalized through Strategic Plans for five years. The second Strategic Plan for 2006-2010 defined 6 strategic axes: 1) universal access to prevention; 2) universal access to treatment and care; 3) protection and support of orphans and vulnerable children; 4) uptake of the fight against HIV/AIDS by actors; 5) promotion of research and epidemiological surveillance; and 6) reinforcement of coordination, management, partnerships, and evaluations (Ministère de la Santé Publique Cameroun, 2006). Since 2007, antiretroviral drugs (ARV) are free of charge in Cameroon. Major contributors to the free distribution of these medicaments are the Global Fund and the Clinton Foundation, while the World Aids Fund offered 50 million Euros for the period 2007-2009 (Evina Mbo, 2005; Nana-Fabu, 2001).

[67] The first aim is subdivided into the following goals: increase in the use of contraceptives in both urban and rural areas; mapping out of less risky maternity strategies; reduction of the number of unwanted and early pregnancies as well as provoked abortions caused by adolescents; promotion and guarantee of high

quality reproductive health services, available and accessible to all segments of the population; and effective handling of the health problems of mothers, adolescents, and elderly persons. With regard to the second aim, specific goals are: the intensification of the fight against epidemics; the promotion of less risky sexual behaviour among youths of 15 to 24 years and women; the designing of development programs for curbing the transmission, from mother to child, of HIV/AIDS; the guarantee of security in blood transfusion; the creation and vitalization of structures for public handling of persons living with HIV/AIDS, including home care; and the sensitization of heads of enterprises on the necessity to take charge of people living with HIV/AIDS and their families. The other major strategic aims that are mentioned with regard to health are: 3) the improvement of vaccination coverage; 4) the improvement of the nutritional condition of the whole population; 5) the intensification of hygiene and sanitation; and 6) the intensification of the fight against endemic diseases (Ministère de la Santé Publique Cameroun, 2001a).

[68] The priority components of reproductive health in Cameroon are: mother and child health (low risk maternity, care for newborns, abortion care, nutrition); family planning (information, education, and communication); the fight against STDs and HIV/AIDS; reproductive health care of adolescents; the fight against infertility and sexual dysfunctions; reproductive health for aged people (menopause/andropause); the fight against genital and breast cancers; and the fight against nefarious sexual practices such as female genital mutilations, early marriages, or sexual and domestic violence. These components are further specified into sub-sections dealing with women's health, child health, youngsters' health, and men's health respectively.

[69] According to this law, every woman who procures or consents to an abortion will be punished with imprisonment from fifteen days to one year, or with a fine ranging from 5,000 to 200,000 CFA Francs, or both. The person who performs the abortion on a woman, notwithstanding her consent, is to be punished with imprisonment varying from one to five years and with a fine of from 100,000 to two million CFA Francs. These penalties are doubled where the offender engages habitually in abortion or practices the profession of medicine or an allied profession. In this last case, the court may also order closure of the professional premises and impose a ban on the offender's occupation.

[70] The objectives of this post-abortion care (PAC) are to take care of complications of abortions and to prevent recurrence of abortions. Practically, this care comprises: a post-abortion diagnosis; immediate care of abortion (curettage and prescription of medicines); care of the causes of the abortion; counselling with regard to family planning; and family planning services (Ministère de la Santé Publique Cameroun, 2001b).

[71] This point was made drastically clear during the official visit of the Pope to Cameroon in March 2009, where he condemned the use of condoms by African people. Rather than *preventing* the AIDS problem on the continent, he stated, condom use would only *aggravate* the pandemic. In the Pope's opinion, only a responsible and moral attitude towards sexual relationships would help to fight the disease.

[72] For example, only pharmacies are permitted to sell contraceptives – some of which should be ordered with a doctor's prescription (law n° 80/10 of 14 July 1980). Sterilization is only accessible to women of at least 35 years of age and who have five or more children. In many practical situations, the authorization of the partner is demanded in order to be able to obtain contraceptives, whereas no law prescribes service providers to do so (Beninguissé, 2005).

[73] I had identified eight larger aetiological 'categories' through the free listing and pile sorting methods described in more detail on page 56. These were elaborately discussed and, if needed, corrected or complemented by my informants in the focus groups. Then, I asked them which aetiological categories were experienced as 'difficult to live with or treat' and which ones were relatively 'easy to live with or treat'. The different causes of pregnancy interruption were thus ranked according to complexity and severity. See Ross et al. (1998) for another example of the use of this method in Bangladesh.

[74] This biographic narrative method has been introduced by Fritz Schütze and was further developed within the interactionist and phenomenological research traditions by Fischer-Rosenthal (2000) and Rosenthal (2004), who focus on biography as a sociological method to understand both the persons interviewed and the society in which they live. Wengraf (2001) elaborated the method into a detailed interview model comprising three sub-sessions; this model has been put into practice by for instance Fischer & Goblirsh (2007). Although my own biographical methodology was not as structured as proposed by the models mentioned above, the analytical sequence and underlying assumptions are nevertheless comparable.

[75] The understanding and presentation of the self that evolves within the interactive practice of autobiographic narration has been elaborately described by Fischer & Goblirsch (2007) and Fischer-Rosenthal (2000) who talk about 'biographic structuring', as well as by Rosenthal (2003) who explores the healing effects of this process.

CHAPTER 2

[1] The situation whereby a new pregnancy comes along while a woman is still nursing a child is called *odangla mon* (‘*tu as traversé l’enfant*’; ‘you have passed over the child’). Not only would it publicize a woman’s transgression of the post-partum sexual taboo, but it also endangers the nursing child’s health. The impoverished quality of breast milk, as well as the odours of the new pregnancy, would make the child suffer from diarrhoea, nausea, apathy, and, if no remedies are sought, eventual death. Therefore, women should preferably wait for the nursing child to be able to walk – and thereby gradually forget about the breast – before they conceive again (see also Fru, 2008, p. 57).

[2] Nivaquine® is an anti-malarial drug based on chloroquine that poses risks of foetal damage during pregnancy. Due to its availability and affordability in the village, many women use it quite effectively as menstrual regulation or abortion device. This is, however, not without considerable health risks, especially since women prefer to take an overdose so as to provoke a quick interruption of their (possibly developing) pregnancy.

[3] Diana had already borne five girls and only one son with different men. Joëlle was Baudouin’s first child. Although both Diana and her husband longed for a son, Diana was convinced that she had the ‘blood of bearing daughters’. During my next fieldwork period one year later, however, she gave birth to a son, whom she called ‘Erique’ (the male version of my name) and who was an important source of pride for her husband Baudouin.

[4] I talk about pregnancies that ‘enter’, because that is how local expressions have it. In French, women say that ‘*la grossesse est entrée*’; in Gbigbil they relate that ‘*ayadīm abum*’.

[5] The transparent body on the paper was presented in reverse position since earlier interviews had revealed a general perception that a developing foetus is attached to the back, with the placenta ‘stuck’ to the spine.

[6] One informant once mentioned that especially the first few periods are ‘thrown into the bush’ and cannot lead to conception – an idea that is also described for the neighbouring Beti by Laburthe-Tolra (1985). However, many others state that from the very onset of menses, girls are capable of conceiving. With abhorrence they state that a premature onset of sexual activities might even lead to conceiving a pregnancy without having ever seen a period.

[7] Local healers and old *mamas* in the village showed me different remedies to ‘kill the worm’. These include, among others, the leaves called *tuey* (*Cassia alata* Linn)*, enounoumba* (*Ageratum conyzoides*)*, abomling* (*Piper umbellatum* Linn.), the roots of *lunkon* (*Asparagus warneckei* Hutch), and the liana called *ndik mikongo* (*Adenia letouzeyi*). I have been able to determine the botanical classifications of these tropical plants with the help and insights of researchers of the Biosystematics Group at Wageningen University in the Netherlands.

[8] Although people do not associate the *vers de femmes* with occult forces, the visualizations and classifications of this internal worm reveal interesting similarities with local witchcraft beliefs. Like the women’s worm, the power of witchcraft (*ivū*) is also conceptualized as a small animal (a crab-like or mouse-like creature) that is located in the belly, good or bad in nature, capable of destroying (foetal) life, and only detectable (and treatable) through indigenous methods.

[9] My informants repeat words (in Gbigbil as well as in French) in order to emphasize the meaning of the word. ‘Water water’ here thus means that a beginning pregnancy contains just fluids and not more than that.

[10] My informants spoke about the Gbigbil word *sīsīm*, which they translated using the French word *esprit* (spirit). While *sīsīm* could indicate either an external ‘ghost’ or one’s inner ‘soul’, it was clear from the context and contents of the conversations that my informants pointed to the latter sense of the word here.

[11] Other remedies mentioned by my informants entail the burial of a snail shell filled with a menstrual cloth under the cooking fire in the kitchen, the burial of a needle that has been drenched in menstrual blood, or the throwing of a sanitary towel in the fields while expressing the wish that the ancestors will take the childbirth potential away.

[12] Metaphorical associations of pregnancies with the eating of bananas are widespread in Cameroon. In his book about popular language use in Cameroon, Fouda writes: ‘With the masculine sex being similar in its form to the fruit of the banana tree, they say that a girl has swallowed it as they notice that it has stayed in her belly’ (Fouda, 2004, p. 79, my translation).

[13] Some informants mentioned that pregnancies might be ritually confirmed through the acceptation of a symbolic package of food from female in-laws. By starting to eat the contents of the package, the receiver implicitly admits her pregnancy. Angélique recounts, ‘My sister-in-law and co-wife told me, ‘Here is our package that we give to you. Eat this *mbol,* since we know that you are pregnant’. And you take it. Since you know they speak the truth, can you still deny it? You just laugh’. Angélique cited alternative gifts as

well, such as a package containing a mix of pepper, nuts, and fish, or any sour fruit, which is something pregnant women are believed to crave for during pregnancy.

[14] Analogies reach even further, as prescriptions do also exist for the father of the child-to-be. Next to his duty to attend to all the wishes and support all the whims of his wife or girlfriend, he is not supposed to eat or kill certain bush animals (red hare, porcupine, or snake), or consume certain foods (like chicken or pork) in the absence of his partner. While resorting to sexual activities with other women towards the end of gestation is something that every father-to-be claims to be unavoidable, he should nevertheless refrain from sharing the bed with others while his wife or girlfriend is giving birth to his baby – lest the latter will be blocked or refuse to be born.

[15] Indigenous 'vaccination' entails a different procedure than the use of syringes that is implied in the biomedical sense of the word. In the village, to apply a 'vaccination' is to make an incision in the skin and rub a mixture of herbal medicines in it. Photo 4 shows how some blood is flowing from the fresh incision in my informant's lower waist. After the photo was taken, a leave concoction, known for its 'widening effect' on the pelvic bones, was rubbed into the wound. The evaporation technique works as follows: firstly, shells of cucumbers have to be prepared with certain remedies in an old pot on the fire. Then, the pot is placed under a bamboo bed, on which the pregnant woman has to sit with bare buttocks covered by a skirt. The steam of the cooked concoction will pass through the openings in the bamboo bed and enter the vagina, where it has a widening effect.

[16] Formally, women are not allowed to become a *matrône* as long as they are still bearing children themselves. Helping women to deliver is supposed to block your own childbearing capacities. In this respect, one woman told me that her husband forbade her to assist a delivery when she was called upon for help, since he feared her subsequent infertility. In practice, however, where deliveries take many women 'by surprise' and need quick intervention, even childbearing women might end up helping their sisters in giving birth.

[17] Underwear symbolizes a woman's fertility because of its direct contact with a woman's genitals, her vaginal secretions, and menstrual blood. A grinding pot has been indicated to symbolize the womb by other studies as well (Adetunji, 1996; Feldman-Savelsberg, 1996, 1999). Similar suspending actions are also described by Taylor (1992) for Rwanda. He calls them poisonous spells which may not only impede a woman from delivering her baby – since the baby rises towards the heart or turns into a transversal position – but could also prevent her from conceiving again.

[18] In his descriptions of birthing practices among the Beti, Ombolo talks about *akia* which seems comparable to *bikaka.* He writes, 'In fact, when one inoculated a girl with *evu*, one could extract from her the promise to hand over [to the world of witchcraft] all the children or part of the children that she would bear. With the girl having uttered this promise in secret and fearing to unveil the pact, it was difficult to discover that the woman was a victim of such a fatal agreement with the occult forces until it [i.e. the agreement] started to produce its effects. Also, it is generally when the woman had lost one or more newborn children or children of young age that her surroundings suspected the existence of an 'akia' and would invite her to reveal [the secret pact]' (Ombolo, 1991, p. 257, my translation).

[19] These massages can be performed in a lying or sitting position. In the latter case, *yal* sits naked opposite another woman who sprinkles her with cold and very hot water through rapid movements with a wetted traditional broom. Many young women reassure me that the massage, though necessary and effective, is very painful and that they often scream out loud in fear of being burnt. Although Laburthe-Tolra (1985) interprets a comparable habit amongst the neighbouring Beti as a simulation of the screaming of women during sexual intercourse, I never heard Gbigbil women make this comparison.

[20] In this respect, different treatments are mentioned which involve the leaves *tuey, iteli, adoli, ilumkil, enounoumba* (*Ageratum conyzoides*), the liana *ndik mikongo*, and the barks *mom* and *isol*.

[21] In contrast to what has been stated by Beninguissé (2003, p. 19), my informants did not display a 'latent need' to determine the sex of their foetuses. Although some might try to influence the sex of the next child *before* conception – by wearing the underwear or wrapper (*gol*) of a woman who has given birth to many children of that particular sex, or by chewing certain leaves that have a long version (for boys) and a short version (for girls) – I did not hear of any divinatory sessions or indigenous treatments used *during* pregnancy in order to determine or influence the sex of the developing child. It is thus not for the specific purpose of knowing the sex of the child that ultrasounds were applauded or consulted.

CHAPTER 3

[1] This excerpt was recorded during the funeral of Gabrielle, a young woman from Asung who had gone into a marriage in another village, where she aborted two pregnancies out of anger over her husband's negligence. Her second abortion attempt had proved fatal. A lack of bride-price payments had incited Gabrielle's family to demand the burial of their daughter in their own village – and not in the village of her husband. This in turn served as a catalyst for the married women in Asung to ritually refuse this burial on 'the ground on which we work so hard every day'. In their revolt, these 'wives' of the village started to insult the 'daughters' of the village, like Gabrielle, by commenting upon their despicable marriage habits – and comparing these with their own laudable conjugal commitment and work ethos. In an animated atmosphere, norms of womanhood and wifehood came to be discussed, imposed, and contested between older 'outsiders' (the 'wives' who married into the village) and younger 'insiders' (the unmarried 'daughters' of the village). Interestingly, the specific cause of Gabrielle's death was *not* mentioned in these discussions – an avoidance which reveals how abortions (and their possible disastrous consequences) are considered to be shameful affairs that should remain hidden (see also Bleek, 1981).

[2] In fact, Yvette's sister-in-law is the daughter of the sister of Yvette's father-in-law. Having special rights, privileges, and ritual obligations as a *mo kal* ('child of the sister') towards her avuncular family (mother's brother patrilineage), she is considered to be the one to 'talk with force in case of problems'. Indeed, cousins have been described as having an ambiguous but powerful position with regard to the lineage of their maternal uncles in this region (Geschiere, 1982; Laburthe-Tolra, 1981).

[3] *Mesot* is a general term comprising different varieties of an indigenous divination and verification method. What all those varieties have in common is that certain natural objects (most often leaves) are posed a particular question. The subsequent movement or characteristics of the objects form the answer to the question. One informant who aimed to discover the cause of the death of her child through *mesot* explained, 'I went to do the *mesot.* It means that you take leaves and you talk to them, and you come and verify during three days. I took three leaves. To the first I said, "If my child died because of tuberculosis, it should be eaten away. If not, I will find the leaf untouched". To the second, "If they have killed my child like that through witchcraft practices, this leaf should be eaten away". To the third, "If it were the uncles who have killed, I will find this leaf eaten away. If that's not the case, I will find it like I see it now". After three days, I found that the leaf of the witchcraft and the leaf of the tuberculosis had been eaten away'. In the case described by Suzie, the question was not whether the leaves would be corroded or not, but whether or not they would fall down.

[4] Although discourses about '*le diable*' (the devil) and '*la sorcellerie*' (witchcraft) have different sources of origin – with the former being introduced by Pentecostalists in Cameroon and having more religious connotations than the latter – they were used interchangeably by my informants.

[5] In fact, the ideas about babyhood and interrupted pregnancies that will be discussed in the following two sections possibly apply *beyond* the village sphere as well. But even if these notions may be omnipresent and widely shared, this chapter aims to unravel how they become particularly relevant and incorporated in the interpretations and projects that emerge around interrupted fertility in the *rural* setting. An understanding of their meanings and implications will prove to be indispensable for making sense of reproductive experiences and decisions that happen in, and are specific for, the village.

[6] Spiritual connection diminishes in particular once children have attained a certain level of knowledge and communication skills, for once they are able to talk and participate in the 'human' world, the risk increases that they would reveal spiritual secrets to their human elders.

[7] Since witchcraft is believed to be 'given' through the umbilical cord, a newborn *mon* is considered very vulnerable to evil interventions until the cord releases. Not surprisingly, many women carefully hide their newborns inside the house and cover this umbilical cord with remedies – such as traditional salt called *kangwa* or pulverized mushrooms called *iso* – to enhance the process of desiccation.

[8] Probably not coincidentally, this is also the place where the spirits of persons mystically killed by a form of witchcraft called *famla* or *mekwain* are believed to go. Witches operating in the world of *famla* are supposed to 'sell' their own relatives, who will physically die in the visible 'human' world but whose souls will be transferred to the mystical surroundings of Douala and Mont Kupe. There, they have to work hard on invisible plantations. The 'owners' of these souls get rich through the fruits of their victims' labour. These beliefs of *famla* originally come from the coastal area in West Cameroon (Fisiy & Geschiere, 1993). One informant explicitly mentioned the provenance of some newborn babies from the world of *famla.* She said, 'Old women often say that some children come from the world of *famla.* They call those children *bon mekon.* For, *kon* is the Gbigbil word for *famla.* It concerns people who don't want to work in *famla* anymore. They say, "I will enter in a new body so that I can be born again". And those children live'. That *kon* (or

kong) is indeed a word used by Beti people to indicate the world of *famla* is confirmed by Ngono (2002), Mallart Guimera (1981), and Fisiy & Geschiere (1993, p. 115). Earlier it has been mentioned, however, that my Gbigbil informants also speak of *ayong bekon* to indicate the realm of the dead in general. Clearly, some ambiguity exists regarding the exact provenance of babies.

[9] In the first few days after delivery, the baby's skin is rubbed with eggs and red powder (*bole*) to render it healthy, beautiful, and protected. Afterwards, when *mon* is allowed to be bathed, several protective leaves or remedies for 'luck' or 'love' in life can be added to the water. Further, certain cords will be attached to the waist, ankles, and wrists in order to make the child gain weight quickly and to protect him or her against typical 'child illnesses' (*akón abongo*).

[10] Indeed, the huge attention to the physical consequences of a pregnancy interruption for a woman, to be discussed in the next section, stands in stark contrast to the quick disposal of the physical remnants of uterine tissue or the dead foetus. In the first case, the expelled blood clots will be thrown into the deep hole of a toilet or on a garbage heap. Women might do this on their own if their physical condition allows them to and if they do not want others to know about the happening. In cases of interruption of more advanced pregnancies, where the foetus has taken its human forms and is expelled through a labour-like process, women will be assisted by others such as female family members or a midwife. Midwives will quickly hand the foetus over to the men in the family – especially the woman's brothers-in-law. These men will wrap the foetus in leaves (*adoli* and *long*), sheets, or a plastic bag and bury it immediately next to the woman's kitchen, often without the mother or other family members being present. On top of the grave, savannah leaves called *long* will be planted to symbolize the contact between the dead foetus and this (living) world. This symbol, just like the many words of comfort women may receive from visiting friends, neighbours, and sisters, stress a quick return of a new pregnancy in the near future. 'You have conceived and you will always continue to conceive' or 'a child will always come again' are typical expressions in this respect. In order to enhance this quick return of fertility, several social conventions surround a woman whose pregnancy was interrupted. First, she is not allowed to cry or mourn, since this would hamper the coming of a new child into her womb. Second, she should have sexual intercourse with the father of the interrupted pregnancy at least once before sleeping with other men. This man is thought to have 'taken' the woman's fertility, which she can only get back by sleeping with him. Third, no man other than the one who impregnated her is allowed to hit her on the back, lest her childbearing capacities might disappear altogether. The presence of these prescriptions confirms people's tendency to downplay what is lost in favour of what is to come.

[11] While the following discussion will explicitly focus on the force of women, it should be noted that ideals and portrayals of *ngul* exist for Gbigbil men as well. Its content can be compared to the force described for Beti men by Laburthe-Tolra (1981, p. 558): 'A young man inaugurates his personal career when, after his first marriage with his first wife (…), he finds the force (*ngul*) to install himself on his own and found a new village'. In the same vein and for the same Beti men, Houseman (1988, pp. 54-55) notes, 'It is to a large extent by virtue of such inheritance – control over actual or potential wives to be kept or distributed to others (younger brothers, sons, clients, etc.) – that a man acquires sufficient personal 'force' to enable him to become an autonomous focus of allegiance, that is, to found a domestic group of his own'. A man's force is thus not only displayed physically, but also in his autonomous ability to form a social group of followers around him. Those unable to do so are called 'a man of nothing' (*mod asumba*) in Gbigbil.

[12] Indeed, one of my informants even attributed her blood loss during pregnancy to her daily doughnut preparation – a tentative explanation which was confirmed by the doctor in the health centre. Only the avoidance of daily exposure to fire heat was supposed to prevent her pregnancy from 'leaving'.

[13] There are many methods that women use to try to prevent such a loss. Menacing pregnancy interruptions are recognized by the warming up of the back, the kidneys, the fallopian tubes, or 'the blood inside'. At this stage, certain indigenous remedies exist to 'calm the belly down' and to prevent the pregnancy from 'leaving'. I was told about different purges of water with the leaves of *ekol asəng*, *noue*, *molom*, *abolom*, the bark *mom*, the roots of *abomling*, or the roots of a banana tree. All these purges are administered to block the flow of blood, to appease the pain, or to 'calm down the child in the belly'. If these do not alleviate the situation, help might be sought at the hospital, where injections are thought to be especially effective. An examination of the registers of the dispensary in the village and two surrounding city hospitals (*Centre Medical d'Arrondissement* in Bélabo and *Hôpital Provincial* in Bertoua) showed that a considerable part of the help sought in (the few) cases of pregnancy interruptions concerns mere *menaces* of interruption rather than incomplete or completed abortions (see Appendix VIII). If, however, all these interventions do not succeed, the loss of 'water' and 'balls of blood' becomes unavoidable. It might take days or even weeks before everything is expelled. The process, once considered inevitable, can be accelerated by indigenous

remedies, such as the cooked leaves of an eggplant (*mekei mesong*), or the pulverized leaves of the tree called *adongsi*, mixed with ginger, pepper, and salt.

[14] In case a woman dies during childbirth without having yet expelled the foetus, a traditional 'operation' will be performed on her in the village before she is buried. Under no circumstances is it allowed to bury 'two persons in the same grave', lest misfortunes will plague the entire family. In the one case that I witnessed where a pregnant woman *was* buried with her foetus still inside, I was told that male *isam* initiates would perform some traditions during the night. By making remedies called *nyəng*, sacrificing certain animals (like white hens, goats, and pigs), and dancing the traditional dance *akong*, they would try to prevent any negative consequences from happening after this unauthorized burial. Not surprisingly, when both mother and child are at risk during childbirth, people will try to do everything to save the mother's – and not the child's – life to prevent such situations from occurring. The moral choice to let the foetus die in such critical moments is termed 'life-boat ethics' by Hardin (1974), and is also discussed by Scheper-Hughes (1992, p. 405) in order to account for maternal decisions in a Brazilian shantytown. My informant Elianne explains the underlying rationale: 'In case of a difficult birth, there are many remedies that people can give you. And they can take you even to the hospital. In order to evacuate the child. To protect the mother. Because we say here that when a mother and a baby fall into the water, you should always rescue the mother. You should leave the baby to die. Because you never know what would have become of the baby, whereas you know that the mother can still give birth to another one'. This moral distinction between mother and baby by Gbigbil informants feeds into the bulk of literature on mother-foetus antagonism (Casper, 1998; Hardacre, 1999; Heriot, 1996; Hubbard, 1994; Ivry, 2009; L. M. Morgan, 1996; Petchesky, 1987; Rapp, 2000) which reacts against phenomenological stances of intimacy and intercorporeality between a pregnant woman and her baby (see, for instance, Wynn, 2002). The critical studies describe how the developments of prenatal technologies, as well as other cultural and historical transformations, have led to reconceptualizations of the body, personhood, and rights of a foetus as distinct from and possibly in conflict with those of the mother. Unlike the Gbigbil precedence accorded to a mother's needs and wishes, however, many of these studies show how in Western settings the preponderance of images and rights of the foetus has often downplayed those of the mother.

[15] Paxson traces a shift from an 'ethic of service', where motherhood is the ultimate and rather unquestioned goal of womanhood, toward an 'ethic of choice' and an 'ethic of well-being', which present multiple options to women and prioritize their personal health and well-being.

[16] While Yvette herself gave many external explanations for the losses of her first three sons, outsiders might as well have found some 'excuses' due to the particular circumstances of these deaths. First child deaths are often minimized by the idea that it could be a matter of 'bad luck' – something which overcomes almost every parent at least once in a life-time. The attribution of the death of Yvette's twins to their supernatural forces could also be reasonable since it was often mentioned in the village. Although some indirect witchcraft accusations had been uttered towards Yvette, she minimized them by saying that these were quite expected in cases of sudden child loss, especially in polygynous marriages. In any case, they were not as explicit and effective as the accusations she encountered after her problematic deliveries.

[17] Louis Mallart Guimera (1981) described similar notions for the Evuzok in the South of Cameroon, where witchcraft suspicions are prone to develop with regard to many fertility problems, such as infertility, miscarriages, premature infant death, or difficult childbirth.

[18] Although these questions explicitly ask for particularities, the aim of this analysis is also, in line with the research design outlined in the introduction to this thesis, to discover some general forms of sociality and individuality that influence reproductive decision-making in vital conjunctures around fertility interruption. As such, it is *through* an in-depth examination of the details of Yvette's life and position, and the comparison of these with the lives and decisions of others, that we can come to more general insights about certain social and individual assets that seem to have an impact on the approaches women take after their pregnancies have been interrupted.

[19] The return of a sister (and her children) to her brothers in case of a failed marriage – which would be comparable to the case of Yvette's grandmother – is quite common and accepted in Asung. Indeed, several *mo kal* (children of the sister) are noted to live with their maternal uncles in the village. But that all these children themselves should bear children and bring them back to their maternal families, as Yvette's mother did, is a highly unusual situation; it means that the patrilineal and virilocal norms are transgressed not only once, but twice.

[20] The interactions between maternal uncles and their sisters' children are often ambiguous, covered by a joking relationship that claims mutual respect but allows both parties to insult, or even curse, the other at certain moments (see also note 23 in Chapter 1) (Geschiere, 1982; Laburthe-Tolra, 1981; Radcliffe-Brown,

1940). The ambiguity comes especially to the fore in the position of *mo kal* within the neighbourhood of his or her maternal uncles. On the one hand, this position is a vulnerable one since *mo kal* is not a direct descendant of the patrilineage. On the other hand, it offers certain ritual powers to *mo kal* which the maternal uncles cannot contest. If the neighbourhood is for instance haunted by unrest, conflict, or misfortunes, *mo kal* can enter to 'speak with force' and kill all the chickens of the household. The ritualized and often rebellious demands for respect by *mo kal* – by for instance claiming the heads of all animals hunted by *ngweej* – underlines the ambiguous, potentially violent, relationship with maternal uncles, which is to be appeased by ritual gifts. While *bengweej* claim to respect the interventions of *mo kal*, they themselves do *not* intervene much in the personal affairs of *mo kal.* This explains why Yvette did not consider her *bengweej* to be a liable source of support.

[21] Similarly, much could be said here about Yvette's tactical deployment of a general idiom of *suffering* in order to claim her innocence and discard all assumed culpability with which she was surrounded. However, since Chapter 5 will consist of elaborate descriptions and analysis of such paradoxical 'portrayals of powerlessness', I have chosen to leave it out of the discussion here and to focus more on particular manipulations of notions of sexuality, marriage, and motherhood.

CHAPTER 4

[1] The story of Sophie's father is quite particular. Having been fostered by his aunt after the death of his parents, when he was ten years old he decided to escape the bad circumstances he had encountered. He offered himself as a servant to a 'white man' in Batouri, who eventually sent him to school. With his primary school certificate (CEP), Sophie's father was appointed as a nurse in a hospital in Douala. A few years later, his position changed into that of a *Chef de Poste Agricole* in his natal village of Asung. A *Poste Agricole* was an institution stemming from French colonial times; its aim was to initiate cocoa and coffee plantations, to distribute knowledge and resources for higher agricultural production, and to 'monitor' labour in the fields. According to my oldest informants, the first *Poste Agricole* was installed in the *ancient village* of Ibudim around 1955. After the forced migration in 1967, another post was created in the new village of Asung. It came with abundant territory for the *Chef* of the post, Sophie's father at the time. It is on this territory that he created his own *quartier*, with his four wives and thirty-six children.

[2] According to Sophie, her father had thirty-six children, all of whom she calls her brothers and sisters. However, upon request for specification she makes a distinction between those borne from the same womb ('*même père, même mère*') and those borne by different mothers ('*même père, différentes mères*') – a distinction applied by Houseman (1988) as well. The sister who raised her during childhood was a biological daughter of one of the co-wives of Sophie's mother.

[3] As described in Chapter 2, my informants distinguish several forms of women's worms (French: *vers de femmes*; Gbigbil: *song munka*). The 'bad' worm that is mentioned here is located in the belly of some women and 'eats' all the blood destined to form a foetus after conception. The woman can become pregnant, but will eventually miscarry. There is also a 'good' women's worm (also called 'the worm of delivery'; '*le vers de l'accouchement*') that causes severe pain in the lower abdomen just before menstruation, but that encourages conception. As soon as the woman carries a pregnancy, the worm stays aside and will only start picking again at the moment of delivery. Both of the women's worms can only be treated indigenously – a treatment that is usually known by older women and claimed to be very effective. When I discussed this frequent occurrence of women's worms with the biomedical personnel in the health centre of the village, they told me that they perceived this local conception as an indicator of severe genital tract infections and sexually transmitted diseases.

[4] Mectizan® (or Ivermectin) is used in onchocerciasis and lymphatic filariasis control programs and is freely distributed once a year among the population of Cameroon.

[5] She took Depo Provera® injections – a method that is highly preferred over contraceptive pills in the region. The fact that women need to be injected only once in three months instead of taking pills on a daily basis poses less risk of forgetting and of discovery by their partners.

[6] The distinction Sophie makes between day and night refers to practices by non-witches and witches respectively. Witchcraft practices are believed to happen at night and be more powerful or detrimental than attempts to use indigenous medicines by people who do not have any occult powers and only practice 'during the day'.

[7] Sophie's change in fertility desires within the context of this polygynous marriage sheds new light on an age-old demographic debate concerning the impact of polygynous marriage forms on fertility levels. Two major hypotheses exist with regard to this question. One camp assumes that the competition between co-wives and their fertility-dependent positions induce higher fertility levels within polygynous marriages. The

other camp counters that the increased level of conflicts, fertility attacks, and marital time-outs would rather lead polygynous women to bear less children during their life-time. Sophie's story shows that these two hypotheses are not mutually exclusive but that both situations can be encountered within one and the same marriage. The question of the impact of the marital configuration on the eventual number of children can therefore, at least in Eastern Cameroon, not be unequivocally answered if the variability of polygynous conjugal situations is taken into account.

[8] The idiom of play is highly relevant here for two other reasons. First, Gbigbil people do metaphorically refer to sexual relationships as 'play' (see also the discourse of the local doctor in Chapter 2). To 'play' with a man or woman, aside from indicating a strategic manipulation of somebody of the other sex, might also simply mean to have sexual intercourse with him or her. Laburthe-Tolra (1981, p. 510) mentions a similar idiom when he notes that sex is, especially for youngsters, something like 'a sexual parade: and they respect the free game, which can only have happy consequences. It is in terms of a play, for that matter, that boys-girls relationships are conceived of. 'Will you begin to play with a girl in the middle of a party without already having played with her in the village?' says the Beti art of flirting'. Second, people often describe the inconsistent and flexible lifestyle of youngsters who explore multiple horizons as one in which they 'play life' ('*jouer la vie*'), before starting a serious, settled adult life (see also Laburthe-Tolra, 1981, p. 511). Since this chapter will show exactly how sexual and reproductive practices are embedded within wider partner plays and explorations of multiple horizons ('playing of life'), I consider the use of the game metaphor as extremely appropriate.

[9] While this chapter focuses on those who move from the rural area into cities with multiple aspirations in mind, it should not be forgotten that many others move in the opposite direction once these projects become foreclosed. Next to Abega (2007), Akuri et al. (2009) have also shown that many women who end up as wives and mothers in the village have for a shorter or longer period tried to 'search their lives' in cities. The authors identify illness and deaths in the family, unforeseen pregnancies, arranged marriages, gender discrimination, and poverty as possible obstructions to women's urban opportunities. This is not to say that their *aspirations* are lost, however; these are often transferred to the children they subsequently bear in the village. I recognize similar trends in the accounts of some of my rural informants and would like to argue that forlorn urban hopes have to be taken into account to explain not only the implications for the future paths of *living* children, but also the interpretations of the interrupted paths of those who died or were never born.

[10] Of course, as Holtedahl (1993, p. 297) has also noted, ideas about the 'good life' in the city are multiple and variable. Depending on their specific stakes and backgrounds, women stress different aspects and advantages of urban residence. The general enumeration invoked here is thus not meant to hold for all women; however, the specific ideas of each and every one of them fits into the larger framework of easy and honourable city life as sketched in this section.

[11] Likewise, Abega notes for the Maka that 'with money circulating more easily in the city than in the village, and the former invoking a myth of ease, [which is] today well overestimated, youngsters, especially young girls, sometimes try to go and capitalize on their charms there, be it in a temporary manner or in a permanent way' (Abega, 2007, p. 132, my translation). Especially in the current circumstances in Cameroon, the idea of a wealthy flow of money in the city is indeed more a 'myth' inspiring hopeful action than reality. In practice, salaries – especially those of women – remain often unpaid for months on end and many female residents *do* have to work on plots of land in order to reduce food-related expenses. The ideals expressed by my informants are thus clearly distorted and tell us more about the woes and worries in the village than about the wealth in the city.

[12] This chapter assumes that secondary education is, unlike primary education, most likely to be found in urban zones in Cameroon. It should, however, be noted that since 2007, a secondary school establishment (CES) has been constructed and made functional in the village of Asung, with the help of Gbigbil elites from the Bibakung family. It would be worthwhile investigating to what extent the ambitions and reproductive management of secondary school students who can stay in the village might differ from those who are obliged to move to urban centres and encounter different possibilities there.

[13] Whenever I mention the word 'modern', I treat it as an emic category. In line with the local meanings and associations of the word, it captures the urban lifestyle and pecuniary honour that my informants aim to achieve.

[14] In this respect, Guyer (1996, p. 13) states that, historically, 'triage into those who will be favoured, through education, fosterage and other training, and those who will be gradually sidelined, is a function of *post*-natal social and cultural processes where capabilities and potentials are identified and tracked during the assiduously labour-intensive series of ceremonials and apprenticeships that made up child-raising before

the era of schools and world religions' (see for an elaboration on this point Bledsoe, Casterline, Johnson-Kuhn, & Haaga, 1999). This statement seems applicable to Gbigbil histories as well. Participants of the most important male initiation rite, called *isam,* were selected by their fathers. Only sons with certain characteristics were deemed capable of undergoing the training and guarding its secrets afterwards. These favoured ones were physically marked by incisions in the back of the neck – and are until today proud to show this proof of their selection.

[15] With regard to the value of personal characteristics in gaining power within an egalitarian society, Laburthe-Tolra notes, '… the possibility remains open to every young, free man, even [if he is] poor in the beginning, to succeed thanks to his dynamism, thanks to his personal talents and capacities (…). The ways in which an adolescent can affirm himself are very diverse: beauty, force, courage, craftiness, intelligence make him eventually worthy of both the favour of young girls, and the esteem of fathers who will be able to 'give' him a wife (…) because he knows to hunt or dance well, because he is a champion in fights' (1981, pp. 831-832, my translation).

[16] Johnson-Hanks (2007) describes how the concept of '*mfan mot*' used to denote a certain kind of disposition and honour that was only applicable to Beti *men*. Underlying cultural schemata linked this male honour to material success and dominion over women; women themselves could not be honourable. The expansion of school, market, church, and state in modern times, however, altered social conditions and cultural schemata in such a way that notions of honour 'stretched to include women' as well (2007, p. 645). Johnson-Hanks argues that although this form of female honour is certainly one that derives from the colonial and postcolonial history, it also draws on long existent notions of honour of the *mfan mot.*

[17] In her study on the urban ambitions of women in Ngaoundéré, Holtedahl notes that women have to cope with different norms and values in the different 'social fields' which make up their urban lives. The respective rules of relevance in each of these social fields 'stipulate what is relevant knowledge and behaviour, and for whom – in short the convertible resources and assets for the attainment of a 'good life'' (1993, p. 275). In current Cameroonian urban zones, there are not only different meanings of what a 'good life' is, but also different perceptions of how it can and should be attained. The question in this chapter is to what extent this affects Gbigbil perceptions and practices of marriage and fertility.

[18] In her article *Traditions of Invention in Equatorial Africa*, Guyer gives an account of how the historical stress on singularity within multiplicity in Cameroon has encouraged continuous inventions and additions to 'the repertoire of possibility', of which the frontiers were always constantly explored. The 'regular creation of effectivity and novelty' (1996, p. 2) which is caused by this process can also be found in current urban zones, offering new horizons and opportunities. The question in this chapter is to what extent such new possibilities are created within, or have repercussions on, the domains of marriage and fertility in Gbigbil women's lives.

[19] In contrast to demographic studies which investigate the change of fertility behaviour in altered environments (such as, for instance, the one of Lee (1992), arguing that fertility levels do not decrease after rural-urban migration in Cameroon), I do not intend to give an indication of changes in macro-level patterns and numerical outcomes. Rather, I delve into, and try to compare, *perceptions* about childbearing in zones with different horizons and opportunities – irrespective of whether in effect they lead to differences in fertility outcomes.

[20] It should be noted that the long-lasting economic crisis and the subsequent delay in bride-price payments are, as noted in Chapter 1, likely to have contributed to this situation as well. Premarital relationships and marital instability are therefore widespread in both urban and rural zones; yet, as this chapter will show, the ambiguities inhering these partnerships become exacerbated when both partners have other – urban – projects (such as education or employment) in mind.

[21] Although my informants made a conceptual distinction between *amitiés* and relationships that might culminate in a marriage, it should be noted that in practice these two categories are often less distinct than portrayed. As will become clear later in this chapter, *amitiés* share some basic characteristics with possible marital relationships and can quickly turn into more serious engagements. Yet, when my informants explicitly stated that something was a 'mere friendship', they seemed to imply that it was at least not their intention to transform this relationship into a more stable and formalized one.

[22] Interestingly, women in Dakar seem to have a similar way of associating promising male partners with fish; they give those men who offer prosperous prospects the name of an expensive fish, *thiof*. Women even distinguish between small, medium, and big/super *thiof* according to men's status and potential for generosity (Nyamnjoh, 2005). In Cameroon, rich men acting as 'sugar daddies' have also been called *cous pliés* ('folded necks') by the informants of Meekers and Calvès (1997, p. 365) and Johnson-Hanks (2006, p. 173).

[23] This is a vision that is also largely promoted and disseminated in the Cameroonian media. Goheen (1993, p. 267) mentions an article in the daily *Cameroon Tribune* that defines women's marriage refusals and their desire to 'live like free girls or to marry only with important men' as a national problem. Women who 'hate marriage because they want to stay in their own families and accomplish everything before thinking of marriage' are designated as 'whores' wanting to control men. See Nyanzi, Pool & Kinsman (2001) for a detailed account of similar ambiguities in Uganda.

[24] *Youtube* is a well-known low-threshold website broadcasting clips, movies, and other videos from all over the world. The reactions displayed in this chapter were retrieved on 11 February 2010, from http://www.youtube.com/watch?v=0XaQJH-0HSg.

[25] In this sense, men are proud to claim that they are '*dangereux*'– i.e. that they are popular and successful amongst the women. Such a public statement is relevant in a context where male desires for sex are naturalized and considered to be a reflection of their biological functioning. In the absence of regular girlfriends, men are liable to become accused of having a 'dead penis' (*abīn wəjaa*) – which poses a serious threat to their masculine pride.

[26] The same vocabulary was expressed by the informants of Meekers and Calvès (1997, p. 365) and Johnson-Hanks (2006, p. 173). Terms like '*ma Meilleure Petite*' or '*mon Meilleur Petit*' co-exist with '*mon petit*' or '*ma petite*', '*mon copain*' or '*ma copine*', '*mon Chaud*' and '*ma Chaude*', '*Cacao*', 'The Hip' and 'Black Coffee' – all of which aim to distinguish between different sexual partners.

[27] Not only are pregnant students allowed to go on maternity leave, but they must also be readmitted in case they have been suspended because of their pregnancies, as stipulates Circular Letter No. 10/A/562/MINEDUC/ESG of 10 January 1980 (CEDAW, 1999; UN CRC, 2000).

[28] Many of these studies have investigated the indirect, non-school related, but nevertheless concomitant, factors which might affect or explain the reproductive decision-making of female students. In their view, the impact of education derives more from the social context in which schooling takes place than from inherent qualities of the schooling itself. They point, for instance, to the fact that women who tend to initiate and continue education come by default from certain socio-economic strata with particular norms about gender, sexuality, fertility, and appropriate reproductive timing (a phenomenon indicated as the 'selection' effect). They also take into account how wider political and economic settings determine – through mass media, for instance – the use and evaluation of certain educational skills in social practice. See Bledsoe et al. (1999) for a comprehensive overview of the debate.

[29] This desire for a married status is especially present if women have already borne one or several children outside of a conjugal framework. It is considered acceptable and often even advisable to bear a first child outside of marriage since it proves one's fertility and is thus expected to increase marriage chances in uncertain times when men do not easily engage. (This expectation is, however, partly contradicted by a quantitative study on the relationship between premarital childbearing and first marriage chances by Calvès (1999), revealing that the increased chance of marriage only pertains to the very first months after childbearing – and thus probably concerns a union with the father of the child. After a certain time lapse the association becomes strongly negative; apparently, men other than the father of the child do not necessarily find a woman's premarital childbearing attractive enough to prefer them over single non-mothers.) Whether their first birth leads to marriage or not, many Gbigbil women surely express a wish to bear second and following children '*dans un foyer*' – a prescription that is moreover often heavily supported by their family members. To bear 'every child with another man' is not deemed honourable ('*digne*'); it would negatively affect a woman's status in two ways. First, having several children with different men exposes a woman's multiple sexual activities. These women are depicted as untrustworthy *bordelles* (prostitutes) – always having multiple partners at the same time. Second, and consequently, such a woman might encounter difficulties in being believed when she claims to carry a pregnancy from a certain man. With her image of 'looseness', the appointed father may refuse to acknowledge his responsibilities by invoking the many other men that might have possibly impregnated her. If, to the contrary, a man *is* willing to engage with her, the fact that she has different children from different fathers might complicate a marriage arrangement. Rare are those men who unconditionally bear the burden of caring for someone else's 'blood'. The sons of other men in particular are rarely allowed to grow up (and, by implication, stay) in the compound of another lineage. Daughters are easier to accept; they will finally leave the compound for marriage and might even offer bride-price rewards in the long run.

[30] *Iwō* is the Gbigbil word for a condition in which a woman's children repeatedly die. Several indigenous treatments of *iwō* exist, which should all be initiated during pregnancy.

[31] Calvès' calculations specify that children conceived within cohabiting unions are approximately six times more likely to be recognized by their biological fathers than those conceived in non-cohabiting unions, and

that the chances of recognition are four times higher for children whose conception was planned and discussed compared to those whose conception was not anticipated or aspired to (Calvès, 2000, p. 452).

[32] One could wonder to what extent the context of an increasing HIV/AIDS prevalence in the region influences this practice as well. Compared to what was found by, for instance, Ng'weshemi et al. (1996), my male informants seemed to change their sexual behaviour less in the face of the pandemic. Yet, there was clearly an increase in awareness of the dangers of unprotected sex over the time of my three fieldwork periods between 2004 and 2009. More research would be needed to investigate how this awareness affects the use of protective measures by both male and female partners.

[33] In 1966, a new marriage law was issued, followed in 1981 by the Civil Status Registration Ordinance. Although bride-price payments were not prohibited by this law, they were dissociated from the legal status of a union. As a consequence, bridewealth no longer determines affiliation or legal paternity.

[34] Paternal recognition of children who are not conceived in a legal union usually takes place at the time of birth registration. This registration is quite widespread in Cameroon, especially in urban areas, because the birth certificate is indispensable during many instances in the child's life: he or she will need it for school attendance, job applications, or for a national identity card. In case the father does *not* recognize his child, his name will not appear on the birth certificate. Before 1981, however, mention would be made of '*père inconnu*', meaning 'unknown father' (Calvès, 2000, pp. 445-447).

[35] Although I present the possible aetiological explanations here in terms of broader 'categories' (discovered through the methods of free listing and pile sorting discussed in Chapter 1), I do not pretend to give an all-encompassing, coherent account of what turned out to be contradicting and varied descriptions by my informants – a critique on the representation of ethno-medical 'systems' that is also discussed by Pool (1994, 2003). Indeed, my statement that different aetiological explanations are used inventively and inconsistently defies the notion of a coherent 'system' that would be rationally and consistently applied in daily life.

[36] See, for instance, Jejeebhoy (1995), who states that education directly increases five forms of female autonomy: 1) decision-making autonomy in the home; 2) physical autonomy in interacting with the outside world; 3) emotional autonomy; 4) economic autonomy; and 5) social autonomy. It is through the enhanced autonomy in all these domains that fertility is subsequently considered to be affected – in rather unilinear ways.

CHAPTER 5

[1] I understand 'distress' not only in physical terms but also, in line with Nichter (1981, p. 403), as 'a broad range of feeling states including vulnerability, apprehension, inadequacy, dissatisfaction, suppressed anger and other anxiety states which might otherwise take the form of an untenable social conflict or rebellion'. I agree with Nichter (ibid., p. 379) that idioms expressing these feelings 'are culturally constituted in the sense that they initiate particular types of interaction and are associated with culturally pervasive values, norms, generative themes, and health concerns'. This chapter will explore such idioms and the underlying meanings and implications for particular types of interaction in the Gbigbil village of Asung.

[2] *Seying Ining* is a women's association initiated by the international non-governmental organization PLAN International, the only NGO effectively present in Asung. In 2009, *Seying Ining* had 28 members (22 women and 6 men). The association has multiple functions: it provides women with tools and knowledge for agricultural activities so as to promote their economic independence; it encourages cooperation by creating female 'working groups' on a communal cassava field and 'support groups' in case of misfortune; it provides support for, and creates awareness of, hospital services and medical interventions, especially in the domain of mother and child health (through a project called '*Projet de survie de l'enfant à Impact Elargi*' (EIP)); and it locates and takes care of orphans in the village. Despite its presence and impetus for activities in the village, PLAN is surrounded by suspicion and ambivalence in Asung. Many villagers complain of the corruption that must be present at higher levels since they 'never receive anything'. Similar assumptions extend to mama Rosie and other representatives, who are suspected of receiving money for their activities in the village – which, in fact, they do not.

[3] An *agent de santé* ('health agent') or *délégué de santé* (D.C.; 'health delegate') is a community member who is part of the community's *committee de santé* (COSA; 'health committee'), which also has a *président(e)*, a secretary, and a treasurer. Health committees are supposed to collaborate closely with local health centres. They were installed after the Cameroonian government revised the primary health care approach in 1987 and proposed a decentralization of decision-making power into peripheral hands. Health agents and committees had to mediate and enhance dialogue between local communities and the health care structure, and thus improve the quality of care and the participation of communities in the

management of health services (see Chapter 1). The particular role of *agents de santé* like mama Rosie is to create health awareness among their fellow villagers, to encourage hospital visits for routine check-ups or vaccinations, to distribute health-related messages and products (such as mosquito nets) in the community, and to contribute to village health statistics (especially about mother and child health) through surveys and measurements in households. *Agents de santé* have been trained and should ideally receive a small remuneration for their activities. In practice, however, collaboration and communication with the health centre is often lacking, and payment postponed or completely absent.

[4] As the epigraph at the beginning of Chapter 3 has shown, Gbigbil funeral ceremonies consist of ritual interactions (*saŋba*) between in-married wives and native daughters of Asung. Throughout this ritual, inherent tensions between the daughters of the village and the women who have come 'from outside' to marry in the village become explicit in a quasi humorous way. It offers in-married wives like mama Rosie an opportunity to denounce the ambiguities and vulnerabilities of their own status as outsiders, and to ridicule their families-in-law (and especially the mothers-in-law) in ways that are otherwise not accepted.

[5] This training in housekeeping chores (cooking, cleaning, sewing) for young women was part of the Catholic mission in Diang, some twenty kilometres from mama Rosie's natal village.

[6] It remains unclear to me whether this particular confession really took place. Different ethnographic sources have, however, noted that witchcraft confessions are increasingly present in the region. While many of these are forcefully or indirectly uttered in court, others are wilfully (though privately) conceded in order to enhance a process of healing; one cannot be cured as long as one has not confessed past deeds and hidden powers. These latter confessions are not per definition negatively evaluated, since in fact they might prevent worse things from happening (Fisiy & Geschiere, 1990; Geschiere, 1997b; Geschiere & Fisiy, 1994). It might be in this respect that mama Cathérine had decided to publicly acknowledge her deeds – if she ever did so.

[7] Formal marriage acts can be signed for monogamous or polygynous unions. This case obviously concerns a formal polygynous marriage.

[8] According to traditions, daughters-in-law need to offer the first products of their fields to their parents-in-law. This *tjəng*, as it is called, might be fresh corncobs or corn-based preparations such as *couscous.* The in-laws are supposed to give a symbolic amount of money in return, whereupon the daughter-in-law is allowed to consume her own production for the rest of the year. If *tjəng* obligations are not respected, harvests might be spoiled and productions diminish. In practice, however, many women do neglect their *tjəng* duties or give it to another person if relations with the in-laws are not good.

[9] This Centre is part of the Provincial Delegation of the Ministry of Women's Empowerment and Family (*Ministère de la Promotion de la Femme et de la Famille,* MINPROFF). It aims to offer 1) moral, civic, and intellectual training for women's economic, social, and cultural empowerment; 2) education of women with regard to responsible parenthood and the protection of mother and child health; 3) support for women's entrepreneurship and their learning of promising trades; and 4) monitoring of the improvement of the living and working conditions of urban and rural women (see further www.minproff.gov.cm). In the specific Centre in Bertoua that Laura mentions, shorter and longer trainings for women in sewing, informatics, nursery care, and cooking are provided. Furthermore, reproductive health services such as prenatal consultations, routine vaccinations, and HIV/AIDS screening and counselling are offered, as well as informative talks about hygiene, pregnancy, and contraception. In addition, informative sessions about legal family affairs (e.g., with regard to marriage and birth certificates or inheritance laws) are organized in Bertoua and the surrounding villages. The Centre also offers funding for initiatives and projects aimed at the empowerment or enhanced livelihood of women. Thirty-nine women's associations are currently supported (personal communication, 15-06-2009).

[10] Pope John Paul II visited Cameroon on 10-14 August 1985 and 14-16 September 1995. Pope Benedict XVI followed him on 16-19 March 2009. During the stay of John Paul II in 1985, a family Mass at the Bamenda Airport was entitled 'God's plan for marriage and the family "from the beginning"'. In covert terms, Pope John Paul II talked about abortion when he stated, 'The transmission of life, so highly valued in your African traditions, and the love which you have for your children – are these not a special part of the "glory and honour" which the Psalm attributes to man? Yes, your glad acceptance of your children as God's gift to you stands to your glory and honour! But today there is a powerful *anti-life mentality*. It is more widespread in developed nations, but it is also being transmitted to the developing nations as if it were the compulsory path to development and progress. On this point I would like to repeat what I wrote in the Apostolic Exhortation *Familiaris Consortio*: "The Church firmly believes that human life, even if weak and suffering, is always a splendid gift of God's goodness. Against the pessimism and selfishness which cast a shadow over the world, the Church stands for life: in each human life she sees the splendour of that "Yes", that "Amen",

who is Christ himself. To the "No" which assails and afflicts the world, she replies with this living "Yes", thus defending the human person and the world from all who plot against and harm life"' (see further http://www.vatican.va/holy_father/john_paul_ii/homilies). It is probably this specific discourse that inspired Laura's schoolmate – albeit her altered version had turned the Pope's words into a *curse*.

[11] This sum of money is the equivalent of half a monthly income in the country, according to World Bank statistics of 2009.

[12] Officially, in order to obtain a free birth certificate for a child, one needs a declaration of birth issued by a doctor as well as a request signed by both parents within two months of delivery (Abega, 2007, p. 222). In practice, however, many women do not give birth in the hospital, do not have a cooperative partner, or consider obtaining a birth certificate only much later in the child's life. In all these cases, procedures are more complicated and should pass through court – a process that costs 2,000 CFA Francs (personal communication, 27-07-2009), plus the *pourboires* (bribes) that need to be paid to the intermediaries and officials in charge. For villagers in Asung, such a belated decision often comes down to a total sum of 5,000 CFA Francs (around 7.5 Euros). Birth certificates are deemed important in the lives of Cameroonian citizens because they are required for enrolment at school, and form the basis for a national identity card. The daily newspaper *Mutation* once noted how most problems ensue when primary school pupils are ready to take their final exams (CEP – *Certificat d'Études Primaires*) for which they need to show their birth certificates. The article mentioned a survey conducted in 2007 by the German NGO GTZ (*Deutsche Gesellschaft für Internationale Zusammenarbeit*) which showed that 36% of the 10,000 surveyed teenage mothers encountered difficulties with birth certificates. The problem seems to be biggest in the East and Extreme North Provinces (Gaïbaï, 2009).

[13] Although I had met Philippe in person several times, I never had the chance to speak privately with him about his own interpretations and experiences of the described events. Most of these are thus narrated in second-hand accounts by Laura. The aim of this case description is not to give an exact reconstruction of reality, but rather to present the narrative constructions, representations, and interpretations of Laura, in order to assess her discursive deployments in the navigation of different reproductive conjunctures.

[14] Quinine is a bitter alkaloid with fever-reducing, anti-malarial, analgesic, and anti-inflammatory properties, which is believed to function as an abortifacient if taken in large quantities. *Kangwa* is a 'traditional salt' (a condiment) which is often used in local medicinal compositions. *Cytotec* is a drug containing misoprostol, which causes uterine contractions and dilation of the cervix. It is used to instigate problematic spontaneous pregnancy interruptions, to provoke early abortions, or to induce labour.

[15] Norplant is a form of birth control developed by the Population Council that is implanted subdermally in the upper arm and remains effective for five years.

[16] See the section on 'suffering and agency' in the introduction to this dissertation for a more elaborate discussion of these studies and their conclusions.

[17] Inhorn (1996, pp. 2-3) has noted that the term 'patriarchy' is polysemous. Feminists mainly understand it as a total system of 'gender oppression' (of females by males) or as 'male domination/female subordination', while anthropologists have tended to look at patriarchy within the domestic realm and family life. Inhorn (ibid., pp. 3-4) merges these two approaches into one overarching definition, which states that 'patriarchy is characterized by relations of power and authority of males over females, which are 1) learned through gender socialization within the family, where males wield power through the socially defined institution of fatherhood; 2) manifested in both inter- and intragender interactions within the family and in other interpersonal milieus; 3) legitimized through deeply engrained, pervasive ideologies of inherent male superiority; and 4) institutionalized on many societal levels (legal, political, economic, educational, religious, and so on)'. The author further contends that pronatalism is deeply engrained in patriarchy. Whenever I talk about patriarchy and its denouncement by feminists in this chapter, I take this all-encompassing definition as a starting point since it seems to best incorporate all definitions and criticisms uttered in this respect. Yet, the rest of the chapter will also show that formal definitions like this one are not able to capture the practical manipulation and actual forms of power that women can have in such systems.

[18] In this line, feminists have attacked many theories which, from the mid-1970s onwards, had speculated about women's innate – and therefore universal – role as mothers. Examples of those essentialist treatises are Klaus and Kennel's (1976) work on 'maternal bonding' and Ruddick's (1980) idea of 'maternal thinking' (Scheper-Hughes, 1992, p. 401). The feminist theoretical framework which, in reaction, took gender subordination (and the psychological processes it involves – see further Chodorow (1978) and Gilligan (1982)) as its starting point and posited women as victims came to be called 'dominance feminism'. In her article which contests its narrow assumptions, Schneider (1993, p. 387) refers to Kathryn Abrams who has

described 'dominance feminism' as 'that strand of feminist (legal) theory that locates gender oppression in the sexualized domination of women'.

[19] Gerrits (2002) presents an overview of anthropological literature in which this line of thinking is confirmed. She states how the lives of infertile women in patrilineal African communities have generally been depicted 'as marked by suffering and exclusion' (2002, p. 234). Gerrits comes to a different conclusion on the basis of her fieldwork among a matrilineal community in Mozambique. While her attempt to move away from the general discourse of suffering around infertility is laudable, the fact that she attributes women's different experiences to the presence of a matrilineal system leaves the assumptions related to patriarchy unquestioned. In this chapter, I want to look critically at the presumed predominance of patriarchy as portrayed in these studies, and as present in my own field of research.

[20] The two experiences could therefore be considered as fitting two separate strands of research which are tellingly called 'power feminism' and 'victim feminism' respectively (Schneider, 1993, p. 394). Of course these are just two of the many subfields and movements that feminism comprises. Yet, the predominant dichotomy which they more or less explicitly presuppose is also widespread in lay thinking, as has been indicated in the introduction to this dissertation.

[21] Of course, this broad generalization does not do justice to some excellent and detailed studies that have described the complex power intricacies in both abortion cases and infertility experiences all over the world. See, for instance, Feldman-Savelsberg (1999), Gerrits (2008), Inhorn (1996), Olarte Sierra (2010), and Rapp (2000).

[22] Some of these feminists have proposed to work with the concept of *relational autonomy* (Mackenzie & Stoljar, 2000; Nguyen, 2011; Pollack, 2000; Schneider, 1993). In highlighting the social embeddedness of agency, this concept 'provides a helpful theoretical framework in which to explore the space between women's victimization and oppression and women's active responses to these conditions, and in so doing helps to dislodge the victim/agent dichotomy' (Schneider, 1993, p. 84).

[23] Lock and Kaufert (1997, p. 3) explain their stance as one that avoids explaining women's behaviour and subjectivity on the basis of gender alone.

[24] Inherent to this development thinking is a discourse of self-improvement and self-actualisation that focuses explicitly on the individual. In fact, in creating possibilities for greater autonomy, empowerment is seen as an individuating process in itself. This individualistic or psychological notion of empowerment, as well as the linearity that underlies related discourses, has been criticized by Cornwall (2007a) and by feminists who propose to see (the attainment of) autonomy as a *relational* affair (see note 22 above).

[25] In an elaborate review of infertility studies in Cameroon, Lantum (1976, p. 31) draws attention to the absence of (demographic and other) studies on abortions in the face of a whole body of literature on infertility when he states, 'The incidence of abortion has not been studied in the areas where the sterility rate is high [i.e. in East Cameroon] in order to estimate the contribution which abortions could add to the problem of sterility and low natality rate'.

[26] This diary excerpt (n° 703-5) was written between 1970 and 1972 by Father Willem de Jong, who explicitly focused his attention on marriage traditions and family life in Cameroon. In this excerpt, he described the four issues in detail, and situated and interpreted them within relevant social and historical contexts. Through this contextualization, he argued for a more comprehensive understanding of, and flexible adaptation to, encountered realities in the field. This specific excerpt was retrieved at the archives of the *Congregatio Sancti Spiritus* ('Congregatie van de Heilige Geest') in Gemert, the Netherlands, in August 2007.

[27] *Sixa* (allegedly a derivative of the English word 'sister') was promoted as a school where young women would receive proper education in Christian dogma as well as in household and conjugal affairs before being baptized and marrying in church. According to Criaud (1990, pp. 77-78), the length of the training depended on 'the [level of] education and the conduct of the women. A pagan woman who ha[d] not yet had any education should stay for at least six months in *sixa*'. Indeed, many women of various ages and (marital and familial) backgrounds gathered in the *sixa* for different periods of time (Vincent, 2001, p. 52). 'Free' daughters in particular were sent by their parents or forced by missionaries to participate. Other young women were sent by their Christian *fiancés* who anticipated a religious marriage immediately after the training. Further, as a pathway towards a monogamous Christian marriage, the *sixa* institution also appealed to women who were already married; it served as a refuge for those in polygynous unions or in otherwise badly perceived marriages. While most women envisaged a new life as a Christian wife, others joined the *sixa* in order to get rest and enjoy the harmony between 'sisters'.

[28] This Ministry was officially installed through decree n° 2005-088 of 29 March 2005. It united the former Ministry of Social Affairs (MINAS, created in 1975 and specified through decree n° 81/295 of 23 July 1981) and the Ministry of Women's Conditions (MINCOF, created in 1984 through decree n° 84/95 of 26 March 1984),

which temporarily merged into the Ministry of Social Affairs and Women's Conditions (MINASCOF) between 1988 and 1997. The current 'mission' of the Ministry as presented on the website reads, 'The Ministry of Women's Empowerment and Family is in charge of the elaboration and implementation of measures relating to the respect of Cameroonian women's rights in society, the elimination of all forms of discrimination against women, and the increase in chances for equality in political, economic, social and cultural domains. It is also in charge of the implementation of the national policy on families' (www.minproff.gov.cm).

[29] Some of the anthropologists mentioned above (such as Laburthe-Tolra) have, despite their focus on male dominance, given proof of the existence of female strategies and subversion as well.

[30] Remarkably, while expressions of suffering are abundant, utterances of particular emotional states are almost absent in Gbigbil women's narratives. As is described by Nichter (1981) for Indian women as well, it seems that somatic complaints or symbolic idioms of distress take precedence over concrete discussions about affects and sentiments, whether related to pregnancy interruptions or other experiences. My in-depth analysis of women's complaints of suffering within particular social situations will, however, partly reveal the emotional states and tensions which underlie these idioms of distress.

[31] Similar dynamics were observed decades ago in Ghana by Bleek (1976). He states that while women hold up an appearance of subordination, they hold, due to their genealogical and economic positions, a considerable amount of power. This actual independence of women is, however, covered by their public portrayals of powerlessness.

[32] A similar interpretation of suffering as (shared) strength surrounds stories related to birthing. My informants explicitly stressed the fact that only *women* could endure labour pains and other forms of reproductive suffering. The fact that men would not be able to endure these agonies ('*les hommes ne pourraient pas supporter*') strengthens their notion of a shared female *strength*.

[33] Tellingly, a focus group discussion on agency and suffering was filled with women's constant referrals to themselves as the ones who suffered most – which, apart from creating the atmosphere of mutual understanding that I had hoped for, led to a sort of contest between women impressing each other by their display of personal misery. The acknowledgment of suffering as a marker of good womanhood thus created a common denominator and source of solidarity *within* the group of women, but at the same time formed a foundation for competition and distinctions *between* women.

[34] A report in the archives of the *Congregatio Sancti Spiritus* ('Congregatie van de Heilige Geest') in Gemert, the Netherlands, notes that, 'Due to the underpopulation – 109,000 km² for 600,000 inhabitants – in the East Province of Cameroon, the accent has been laid on procreation. Children should be born, whether in a normal union or outside of marriage' (my translation).

[35] In *The Practice of Everyday Life* (1984), Michel de Certeau argues that contrary to strategies, tactics are the actions of those who do not have the power to calculate and act from an isolated spatial and institutional locality. People who deploy tactics are located outside this dominant defining space, but depend on it to pursue their own goals. Yet, by acting 'from within' the dominant order, they are often more effective in generating change than those who have the power to invent and calculate new strategies.

[36] Tellingly, the theft of one of my own freshly washed underpants which I had installed in the sun created a serious upheaval with regard to the implications it could have for my future fertility if the thief would turn out to be a witch.

[37] As much as the health centre in Asung remains unvisited for infertility problems, the only infertility clinic in Yaoundé has been noted to be largely inaccessible to poor and rural women as well; apart from its geographical and financial inaccessibility, many socio-cultural barriers prevent effective use of its services (Feldman-Savelsberg, 2002; Njikam Savage, 1992). Njikam Savage (1992) describes how artificial donor insemination was introduced in 1985 in the department of Obstetrics and Gynaecology of the University Hospital Centre (UHC) in Yaoundé, and subsequently at the Central Maternity in the same city. While both institutions offered services up to 1989, nowadays infertility treatment can only be obtained at the Central Maternity. The author notes how local cultural frameworks which deny the existence of male infertility form the most important socio-cultural barrier to artificial donor insemination.

[38] In general, stories about men's 'true love' for childless women are quite common in the village. One day, I was sitting with two of my informants in a hangar, when an old man passed by and started to dance and sing in Gbigbil in front of us. After he left as quickly as he had appeared, my informants explained to me that he had been singing about his first wife who was not able to conceive and had been chased away by her family-in-law. The man had taken a second, fertile wife but still regretted the departure of the first one; 'they had chased away his heart'. Inhorn (1996, p. 9) also notes that, even in a strict 'classical' patriarchal society like Egypt, infertility might not only lead to repudiation, but, to the contrary, might actually

strengthen the 'connectivity' between a husband and his infertile wife – a conjugal connection expressed in terms of intense love, involvement, and commitment.

[39] The exact calculation of this 25% is not clarified by Eloundou-Enyegue and Stokes, however. It might as well mean that 25% of all children are fostered out, instead of my interpretation that 25% of the women are fostering children in – an interpretation which makes the rate comparable to the 49% found in my survey.

[40] More precisely, there is one law in the *Code of Canon Law* that refers specifically to abortion. This is canon 1398, which states, 'A person who procures a completed abortion incurs a *latae sententiae* [automatic] excommunication' (Barzelatto, 2004). The Church distinguishes between 'direct' and 'indirect' abortion. Indirect abortion is defined as the (indirect) killing of a foetus in the course of another medical intervention necessary to save a woman's life – a circumstance which is sometimes unpreventable and not aimed at direct destruction of the foetus, hence not morally condemned. Conversely, the church bans direct abortion, even if it is procured in order to save a woman's life – a form of abortion that is legally acknowledged in Cameroonian law and approved by most people in Asung.

[41] An example is the pro-choice organization 'Catholics for Choice', based in Washington, D.C. It was founded in 1973 'to serve as a voice for Catholics who believe that the Catholic tradition supports a woman's moral and legal right to follow her conscience in matters of sexuality and reproductive health'. The organization describes its mission as 'to shape and advance sexual and reproductive ethics that are based on justice, reflect a commitment to women's wellbeing and respect and affirm the capacity of women and men to make moral decisions about their lives. Catholics for Choice works in the United States and internationally to ensure that all people have access to safe and affordable reproductive health-care services and to infuse our core values into public policy, community life and Catholic social teaching and thinking' (http://catholicsforchoice.org).

[42] Despite a few individual efforts and specific awareness raising campaigns of NGOs like the *Association de Lutte contre les Violences faites aux Femmes* (ALVF), no considerable influence at national and legal levels has been reached. To the contrary, liberalization of abortion – a possible implication of Cameroon's signing of the Maputo protocol on 25 July 2006 – has been heavily contested during upheavals in 2009. In article 14 on Health and Reproductive Rights, the protocol proposes to 'protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus' (African Union, 2003, p. 16). Some religious (especially Catholic) authorities and associations in Douala protested against this article. The 'national committee of human rights and liberties' then reacted to this situation by organizing an 'explicatory conference' on the consequences of the Maputo protocol for Cameroon (Solange Yebga, personal communication, 08-06-2010).

[43] Due to formal disapproval surrounding the topic, as well as my own outsider status and probable association with formal institutions, the real incidence of abortions is likely to be even higher.

[44] With regard to biomedical medicines, Van der Geest (2010, p. 17) stresses that it is exactly the possibility of their individual (and secret) application that makes them so popular for abortion use.

[45] In fact, what could be concluded here is that this discourse, as it is used by women, might have negative repercussions for men themselves. Feminists' implicit assumption that patriarchal norms are always automatically directed against women should thus be more nuanced and considered from the men's perspective as well.

[46] General statistics from the World Health Organization (2007) estimate that 13% of the world's maternal deaths are caused by unsafe abortions and their complications. For the specific case of Cameroon, Schuster (2010) mentions estimations of 20-29 unsafe abortions per 1,000 women.

CONCLUSION

[1] It should be noted that fertility interruptions can be the *cause* of this flow of decisions (especially when the mishap happens unexpectedly and seems to endanger previous pathways or projects), or their *result* (especially when the pregnancy is purposefully interrupted because it seems to endanger (possible) pathways or projects). Nevertheless, I argue that these questions influence women's reproductive navigation in the broader conjunctures around *any* pregnancy interruption, whether spontaneous or induced.

[2] In his conceptualization of coincidence, Becker (1994) also mentions the notion of intercontingency. Though he does not define the concept, it becomes clear that what he means is the interdependency between individual actions and choices on the one hand, and the actions and choices that other persons make (or have been making) as a result of contingencies in *their* lives, on the other.

[3] As Cornwall (2007b, p. 239) has also noted, redirection at certain moments in women's lives may retrospectively not be seen as the consequence of conscious decision-making, but as 'an outcome that needs to be coped with, or a consequence of other choices'.

[4] Guyer's broader argument posits that the creation of originality through self-realization resulted in, and was the result of, the societal production of '*multiplicity* amongst *singular* people who were each at their own frontier of experience' (1996, p. 2, emphasis in original). Personal specializations within a particular domain of knowledge or expertise did not only induce and sustain processes of distinction and diversification at the micro level, but also led to interpersonal complementarity that ensured the success of the larger social order.

[5] These idioms carry different connotations than witchcraft stories in, for instance, the Western part of Cameroon, where power has long been centralized and different dynamics are at play (see Fisiy & Geschiere, 1993).

[6] Surprisingly, in the rest of the article from which this quote is taken, Lock reviews in particular studies that have interpreted bodies in terms of their sociality rather than their materiality. Other scholars (see, for instance, Kirmayer, 1992; Lyon, 1997) have criticized this trend in anthropology to either ignore or symbolize the body and argue for a recognition of its material aspects as well.