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Ambiguous ambitions: on pathways, projects, and pregnancy interruptions in Cameroon

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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.

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.

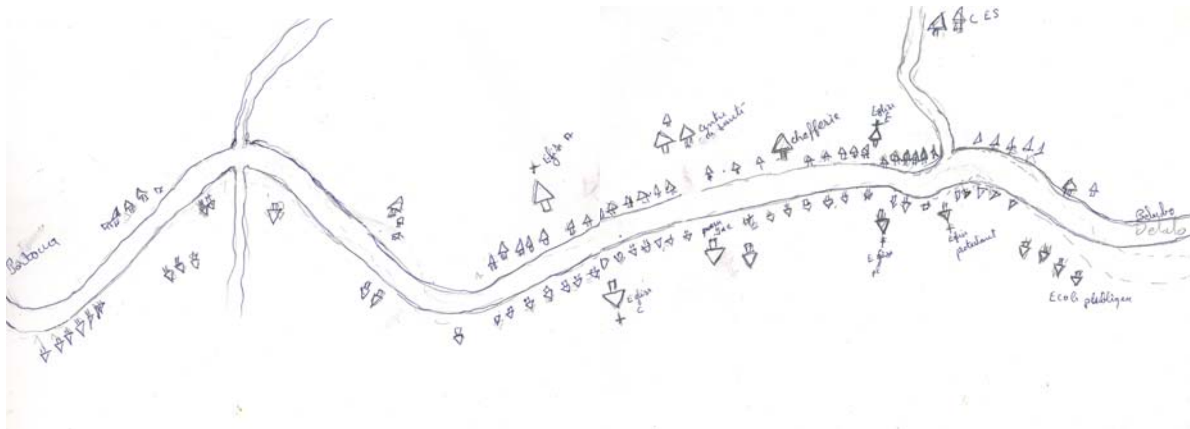

Figure 2 Asung, built alongside the road constructed in 1967 between Bertoua and Bélabo

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 G*roupements 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.