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

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

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

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

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

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

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



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

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

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

Female physiology and fertility: divine destinies to be directed

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

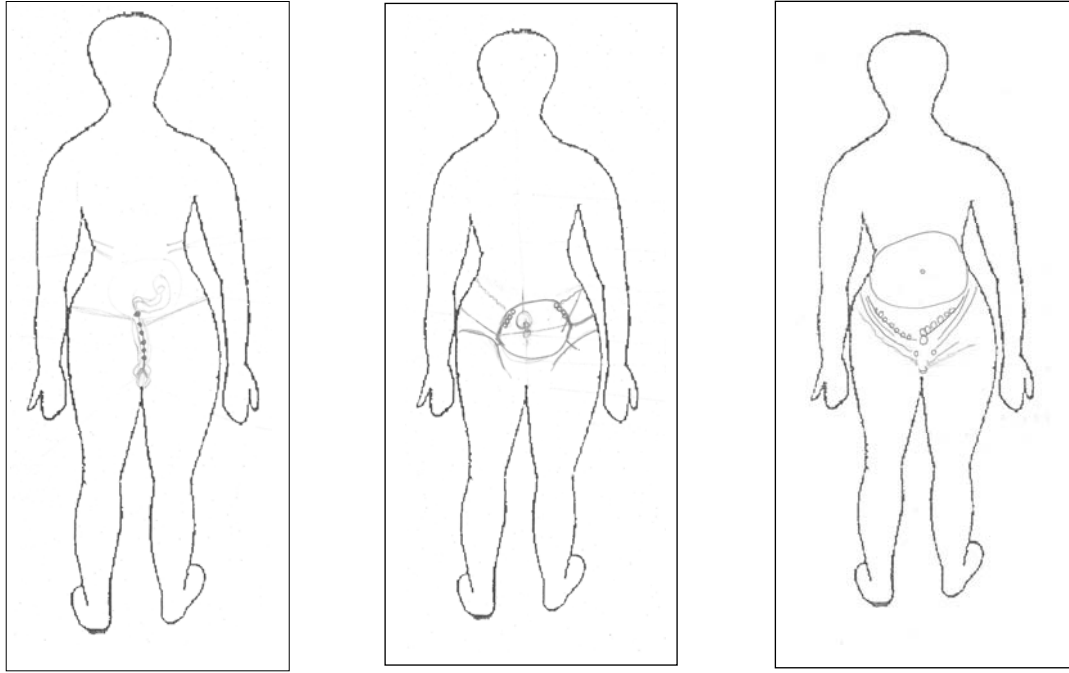


Figure 3 Body maps of the female reproductive system, showing ‘cords of children’

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Filling with force: expected embryology

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

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

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

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

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

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

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

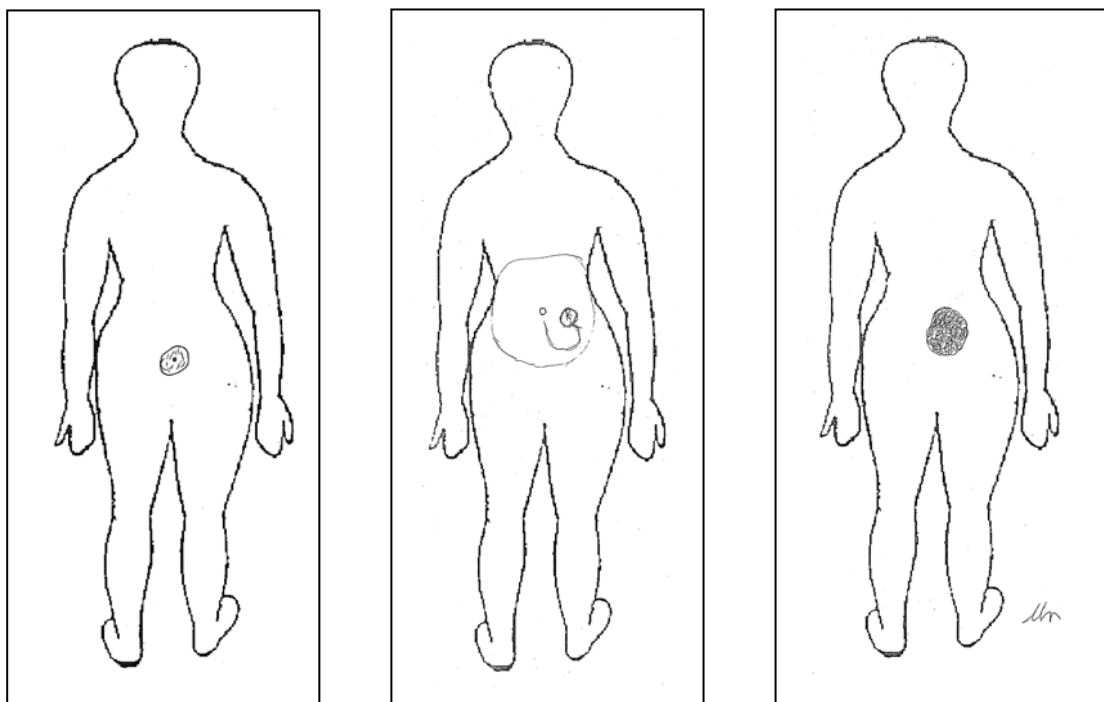


Figure 4 Body maps for a pregnancy at one month

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

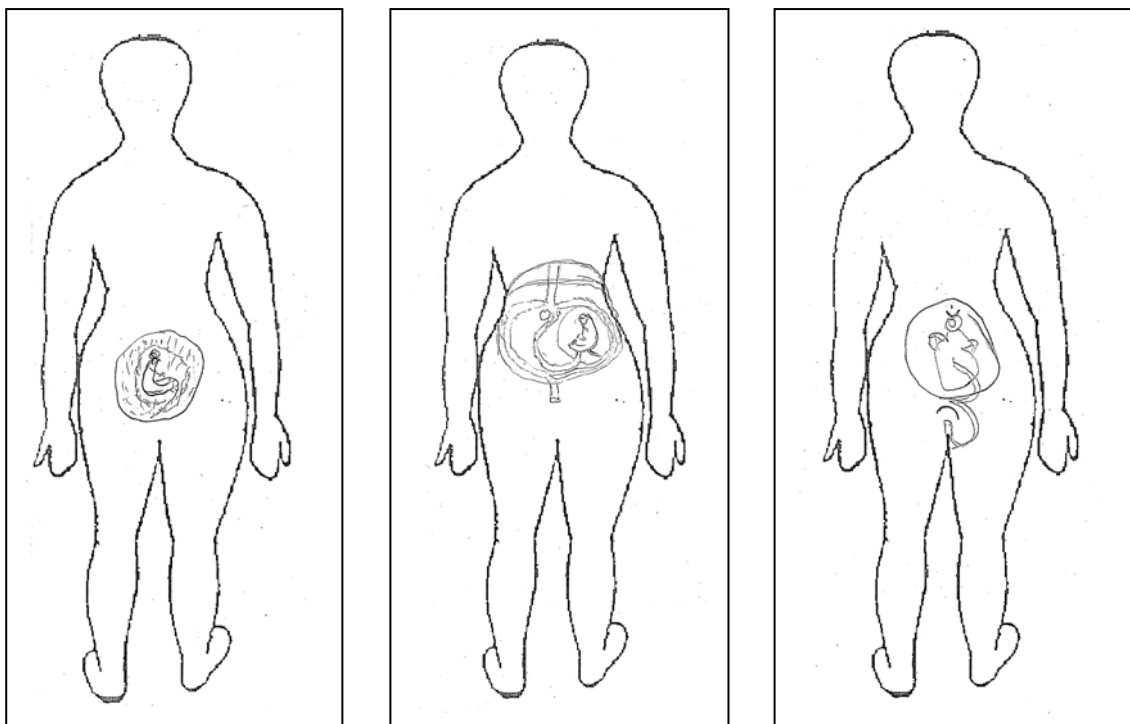


Figure 5 Body maps for a pregnancy at three months

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

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

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

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

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

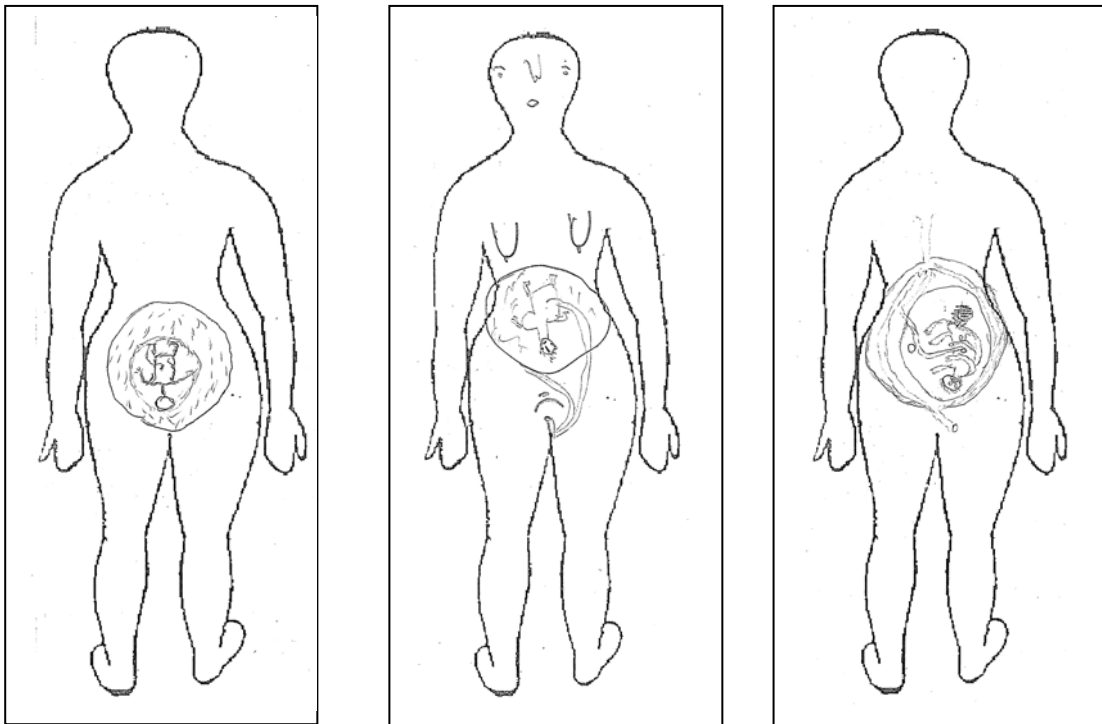


Figure 6 Body maps for a pregnancy at seven months

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

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

Charlotte: If you give birth at five months, and if you have some chance, the child can live. For example, the husband of my aunt was born after five months of pregnancy. He is so old now that people call him 'papa'. When he quarrels with his wife, he says, 'Even if I was born at five months, I am more solid than you are. I can hit you and you will fall'. And it is true: he is very strong!

Me: How do you call these children who are born at five months and continue to live?

Charlotte: *Maman*, how do we call premature children in Gbigbil? [She addresses the co-wife of her father, who answers 'mon kolonde'.] We call them *mon kolonde*. So the child is not born entirely. Like when you fetch water in a bucket that you haven't completely filled. You can use the same word *kolonde* to say that the bucket is not entirely full of water.

Me: From which moment can you call a child 'kolonde'?

Charlotte: From five months. But even at six months it can be *mon kolonde*. And they often tell me that even some children of seven months can be *mon kolonde*. And still, many women give birth at six months. I know a girl who always gives birth at six months. And all these children are normal and alive. But at five months, you should be lucky.

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

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

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

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

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

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

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

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

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

Pregnancies in practice: social sorrows and secrets

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

Pills, pictures, and prescriptions: a continuum of care

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



Photo 6 The delivery room in the health centre of Asung

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

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

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

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

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

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

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

Woman [screaming]: Isn’t it all right now, doctor? Oh, God! It hurts! Gently, please.

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

Sister of the woman: She was alone; she couldn't act.

Doctor: Even her husband wanted to come here.

Sister: You know, we cannot contradict the old *mamas*. For the husband, it's his wife. It is not his daughter.

Doctor: Yes, up to the level that the *mamas* did an episiotomy with their nails! You know, the child that has passed [i.e. died] could have accused his grandmothers in court. Just like this one here [i.e. the woman he is treating]. It's very bad. She stays in the village for her first delivery, whereas she has no passageway. And I had already explained her problem to her! [He inserts a compress into her vagina and demands her to descend from the delivery table. After offering her sister some gloves and bandages, he orders the women to go.]

Sister: What should we do with these gloves? We don't use that in the village.

Doctor: No, you can only cut with your nails instead! That's organized assassination! [To me:] They wanted to deliver at home but it didn't work out in the end, so they came here only in the very last minute. Before that, the old *mamas* were in a hurry and scolded the girl that she should push. Foetal suffering and more and more. No wonder the child has died!

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

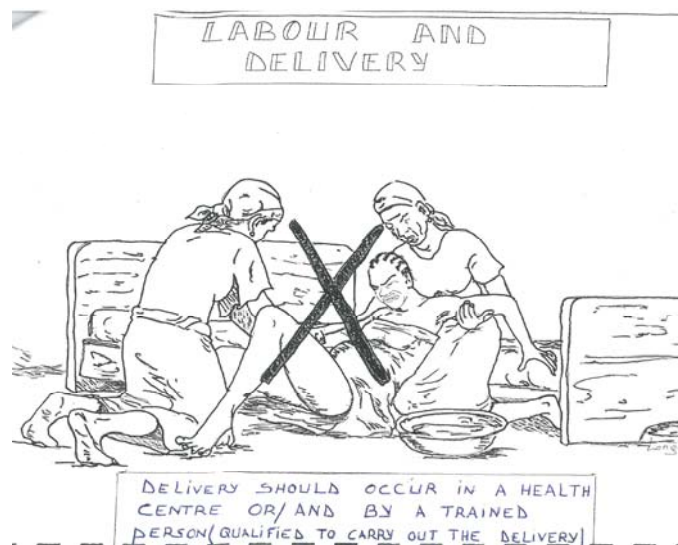


Figure 7 Advertisement against 'risky' home deliveries

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

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

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

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

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

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

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

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

- *I have a problem. I carry my first pregnancy. Here in the village, the mothers often tell me that I shouldn't cut my nails, especially not during a first pregnancy. If I would cut them, the child would not be able to tear apart his placenta on the day of delivery. I would like to know if that's true.* [In reaction to the hygienic prescription to regularly cut nails during pregnancy]
- *Here in the village, they tell us that we shouldn't eat eggs, since the child will be born with dirt in his eyes. His eyes will be closed. What to do?* [In reaction to the recommendation of a protein rich diet during pregnancy]
- *There are some people who say that it is not even allowed to ‘play’, to ‘taste the ball’ towards the end of pregnancy. Is that true?* [In reaction to the metaphorical advice of ‘playing football’, i.e. having sexual intercourse, only intermittently during pregnancy]

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

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

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

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

Louise: Today, I suffer more than on other days.

Doctor: That’s because you don’t come to the hospital.

Louise: I don’t have money. It is hard for me to find even a hundred francs [0.15 Euro cents].

Doctor: Don’t you have cassava on your field which you can sell?

Louise: I am planning to sell some this week in Dangi [neighbouring village where her boyfriend lives]. I am searching money for the transport now. I will sell. Oh, *dokta*, can’t you prescribe everything that you would like to prescribe in my maternity record book? Everything! Even if I don’t take it. But I will bring this to Dangi and present it to my boyfriend, saying, ‘This is what the doctor has prescribed for me’. He will give me that money.

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

Conclusions: social tensions and solitary tactics

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

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

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