Focusing on force and forms in Cameroon: reproductive loss reconsidered

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Current thinking and theorizing about pregnancy and childbirth often take a linear time frame as a starting point. Dominant biomedical embryological notions trace the development of a fertilized ovum into an embryo and, eventually, a foetus that is believed to be viable at a specific gestational age. Consequently, pregnancies are conceptualized as gradual processes evolving over time and expressible in days, weeks, months and trimesters. This time-based rationale also underlies biomedical definitions of different forms of loss during pregnancy. A miscarriage entails the expulsion of an embryo or developing foetus that is believed to be unviable; the loss of a foetus that would have been able to live outside the womb but dies in utero or immediately following delivery is called a stillbirth. When exactly a foetus is considered viable (and thus, when a miscarriage turns into a stillbirth in case of its loss) is understood in terms of gestational time. Most countries have legally established this moment somewhere between 20 and 28 weeks of gestation. Stillbirths during ‘late’ pregnancy – the exact starting point of which varies again between different national frameworks – form, together with deaths at birth and in the first week afterwards, perinatal deaths. Even if these different definitions lack universally acknowledged demarcations, what holds true for all of them is the persistent effort to distinguish between (more or less mutually exclusive) categories of pregnancy loss on the basis of fixed temporal divisions. Definitions of loss after birth are – though
less contested – not less time-based; neonatal, infant and child deaths concern the death of live-born babies within the first 28 days, one year and five years of life respectively.

Such temporal assumptions are often taken for granted in discussions about pregnancy and its disruption in both the global reproductive health arena and the social sciences. Within the current international debates on risks to and of pregnancies in different parts of the world, timing is often critically at stake in the definition of risky reproductive events. There is a strong emphasis on the supposed risks of delivering a baby too early or too late in the gestational process (i.e. foetal age as a risk factor), as well as on risks related to pregnancies that are carried too early or too late in a woman’s life (i.e. maternal age as a risk factor) or deliveries that proceed too slowly or too quickly (i.e. labouring time itself as a risk factor). Notions of linearity – of the gestational process of a pregnancy, of the ageing process of a woman or of the process of childbirth – pervade all of these discussions. International programs aiming to reduce the risks of miscarriage, stillbirth, prematurity and infant mortality during women’s risky reproductive careers all build upon the biomedically-defined successive stages of pregnancy and loss.

Even if some anthropologists have noted that such time-based constructions of reproduction and risk are highly particular and culture-specific (Bledsoe 2002, Downe and Dykes 2009, McCourt 2009), most of the social scientific studies on reproductive loss distinguish between miscarriage, stillbirth, neonatal and infant death on the basis of these same biomedical definitions. Some limit their interest to one of these categories and aim at an in-depth study of loss at a specific gestational phase (Bansen and Stevens 1992, Gerber-Epstein, Leichtentritt and Benyamini 2009, Letherby 1993). Others do consider
various categories (such as miscarriages and stillbirths) together. These studies acknowledge that the meanings and effects of early and late pregnancy loss may not be as different as the separate classifications suggest (Chapman 2003, Earle, Foley, Komaromy and Lloyd 2008, Jones 2001, Layne 2003, Njikam Savage 1996). While the distinct categories are thus discarded on the basis of their comparability – in content or consequence – the underlying time-based rationale remains nevertheless unquestioned. The rhetoric of comparability of ‘early’ and ‘late’ pregnancy losses maintains the separate terms and the inherent idea of a linear gestational process which can be divided into fixed, successive phases. Alternative interpretations of embryological development are thus left unexplored.

In this chapter, I put this chronological common-sense in context and perspective. I hereby build upon the insights of Caroline Bledsoe (2002), who, by deconstructing the idea that linear time is the essence of fertility, denounces the biomedical time-based distinction between miscarriage and stillbirth. She argues that in non-Western contexts, different forms of pregnancy loss can be distinguished on the basis of other criteria. Drawing upon 15 months of anthropological fieldwork in a village in the East Province of Cameroon, I will explore how women of the local Gbigbil community think and talk about different forms of reproductive loss and how these ideas relate to biomedical time-based distinctions. I will do so by focusing on cultural constructs of foetal development and maternal health in this particular locale, where pregnancy losses and maternal deaths abound. In my 2007 village survey, 60 per cent of the 240 Gbigbil women who had ever been pregnant indicated to have experienced at least one pregnancy loss in their lives. Maternal mortality rates were high as well; although it was difficult to obtain reliable
statistics at the local level, the national estimate of 669 deaths per 100,000 births (Barrere 2005), as well as the many stories about women dying during labour and the several ‘near-miss’ cases I witnessed in the field are indicative of the situation. Such reproductive mishaps are, however, interpreted in terms that have little to do with foetal or maternal age, or with any other fixed, temporal classifications. Rather, physical force and forms appear to be the central focus of concern for my Gbigbil informants.

**Filling with forms and force: Embryology explained**

When aiming to understand conceptions and meanings of pregnancy loss in a particular locale, it is necessary to first explore the existing explanations of embryology – i.e. what people think is actually lost. In eastern Cameroon, understandings of foetal development draw upon a wider framework that places blood at the centre of life. As an indispensible vital substance, blood (*mekil*) is the container of physical force (*ngul*); it enables human beings to grow, act and function. Yet, the amount of force in one’s blood is variable over time. While blood is still strong, fresh, and abundant in young people, during life it becomes weaker, dirtier and depleted due to illnesses, heath, physical work and, for women, deliveries and pregnancy losses. The strength of one’s blood determines not only personal wellbeing at a particular moment, but is also of crucial importance for the embryological development of one’s children.

For, it is the blood of a woman and the blood of a man – whose sperm is considered a mere transformation of his blood – that will ‘mix’ and form a mass of blood upon conception. This ‘loose’ substance which is to become a child later on is called *zang mon* as long as it does not display clear human forms. Once it has developed into
something more firm and human-like, the foetus is called a child (*mon*). The exact dividing line between *zəŋ mon* and *mon* is, however, very fluid. The division is not time-based but rather contingent upon a particular process of growing and ‘filling’ of the foetus. This process depends on the strength of the blood of both father and mother; foetuses of parents with strong blood develop quickly, while those inheriting weak blood transform themselves more slowly from *zəŋ mon* into *mon*.

Even when all human features are formed – somewhere between three and five months after conception – the process of growing and filling continues, in order to provide *mon* with force (*ngul*). It is only when a foetus is filled with a certain level of force, that he or she might be viable. 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 the foetus who decides when a pregnancy comes to term by initiating childbirth with the own force. Therefore, the final point of a ‘normal’ pregnancy does not depend on a fixed time frame, but varies according to the parents’ blood strength and a child’s development pace.

Consequently, 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. Rather, it indicates a birth that takes place 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 atoka detaa*) or ‘not filled yet’ (*mon kolonde*). With the pace of ‘filling’ being variable and contingent on blood force of the parents, newborns can be premature at five, six, seven, eight or even nine months.
That it is indeed not time that determines the maturity or prematurity of babies was made clear to me in a discussion with the 29-year-old 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 at five months. 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!

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

We call them *mon kolonde*. So the child is not born entirely. Like when you fetch water in a bucket that you haven’t filled completely. You can use the word *kolonde* to say that the bucket is not entirely full of water.

*From which moment can you call a child ‘kolonde’?*

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 still be *mon kolonde*. And yet, other women give birth at six months and their children are fully normal and alive. But at five months, you should be lucky.¹

¹This quote, like all other quotes in this chapter, has been translated from French into English as accurately as possible. Although people speak the local Gbigbil language, most villagers were able to express themselves fluently in French – the regional *lingua franca* in which this research was conducted.
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’, but it also proves that whether a premature baby continues to live or not depends exactly on the amount of *ngul* present at birth. Of all babies born at a certain gestational age, some may live while others die. That is, some have reached a sufficient level of maturity while others are ‘born before their time’ with too small an amount of force to ensure survival. The irrelevance of fixed time frames as a basis of prematurity and viability was also stressed by the 32-year-old 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 months, she assured me that her child must already be ‘growing old’ in her belly. She reasoned:

In the hospital they say that a child is premature from seven months onwards.
But that is not necessarily the case. I know a woman who always gives birth to perfectly normal children after seven months. In the hospital they also claim that at eight months, the child is dysmature [*dysmaturé*]. That means that it can already be born, it has already everything, but certain organs or functions are not totally developed. But how can that be? Certainly not all children are dysmature at eight months, since others can be born normally at seven months already.

*How would you recognize a baby born at seven months to be normal or premature?*
A premature baby doesn’t cry with force. Whereas other children can be born at seven months and cry with force. The child is strong as it should be. And the premature baby also has no reflex to suck your breast. He has no force to drink. His jaws are not well developed. It is still very tender.

These Gbigbil conceptions of vital force are at odds with 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 risk calculations that downplay physical strength and bodily fitness in favour of measurable time and weight (Downe and Dykes 2009, Einarssóttir 2009). In this paradigm, lack of force is only a mere consequence of a premature birth at a fixed time interval rather than its defining characteristic – as it is for Gbigbil people in eastern Cameroon. Even if the latter also portray the ‘filling with forms and force’ as a linear process, it is not exact time but the variable strength of parents’ blood that underlies the gradual creation of a viable human being.

**Wasted pregnancies and wrong deliveries: Losses explained**

Considering the Gbigbil ideas on embryological development, it is not surprising that their distinctions between different forms of reproductive loss also disregard exact gestational age. Gbigbil women differentiate between the loss of a pregnancy where no clear human being is formed and the loss of a child presenting human forms. A loss happening at the beginning of a pregnancy which contains only the bloody substance of
zung mon is usually depicted as a ‘wasted pregnancy’ (abum ia diggela), a ‘leaving pregnancy’ (abum ia vawa) or a ‘falling pregnancy’ (abum ia song). Once a pregnancy is perceived to contain mon, it has become ‘hard’ and cannot ‘fall’ anymore. Denotations of loss change accordingly; the expulsion of the foetus is now phrased as the delivery of a dead child. Common expressions relate that ‘the child has passed’ (mon ia nul), ‘the child is dead in the belly’ (mon ia wa abum), ‘she gave birth to a child who is dead’ (abiali mon ia wa) or simply ‘the child has died’ (mon awali). Most of these expressions are also used to denote perinatal and neonatal losses or even infant and child deaths. Since completely formed foetuses are already called ‘children’, there is no conceptual distinction between mon inside and outside the uterus. As such, its decease always concerns the loss of a formed child embodying the potential of life – whether that happens before, during, or after delivery.

Tellingly, biomedical temporal divisions between early and late stillbirth, perinatal death, and early and late neonatal death all dissolve into the Gbigbil use of the word fausse couche. Although this French term is formally translated into ‘miscarriage’ in its biomedical sense and thus meant to be associated with the first few months of gestation, my Gbigbil informants use it as a synonym for faux accouchement (‘wrong delivery’) which can only happen after a mon has been created at a later stage of a pregnancy. ‘Wrong deliveries’ thus encompass all cases of reproductive loss where circumstances make it impossible for a mon to live. These circumstances may be related to a fatal ‘prematurity’ of mon – the flipside of the success-stories alluded to above. This is what the 19-year-old Dorine tried to convey during an interview on the meanings of the
term *fausse couche* – a notion I encountered in many cases where I, with my time-based assumptions, had not expected it:

*When can you call something a fausse couche?*

We talk about a *fausse couche* when you are over time for four or five months for instance. You go to the field and you carry your cassava, plantains and bananas on your head. If you fall with this baggage, you might have a *fausse couche*; the child will leave.

*During which phase of a pregnancy can a fausse couche happen?*

It doesn’t have to do with time. If you should deliver tomorrow, but you have an accident today and your child leaves, we call it a *fausse couche*.

*From which month onwards?*

It is not dependent on the month. Even if you have a pregnancy of nine or ten months and you fall badly, the child leaves. All this, we call a *fausse couche*.

Despite my insistence to pinpoint a time interval, Dorine’s insistence to come back to the example of the accident is insightful; it highlights how all births that happen ‘accidentally’ – that is, before the appropriate moment of birth which only the foetus knows – are considered ‘wrong deliveries’ if they end dramatically. ‘Wrong deliveries’ can occur at all moments in time, precisely because they are not dependent on time in its exact sense. At most, as with prematurity, they represent bad *relative* timing – with the
discrepancy between the actual birth and the envisaged birth being too substantial to allow for survival. This contingency of ‘wrong deliveries’ was also explained by Elianne:

When I delivered my daughter at eight months and three days, I thought she would be a *fausse couche*, since my first boy had lasted for eleven months!
But it was a normal delivery. I know now that girls don’t take as long as boys do. My son could never have survived a delivery at eight months.

Next to *fausse couches* being related to incomplete internal developments of *mon*, other ‘wrong deliveries’ might result from outer forces such as witchcraft or illnesses. Many women noted that even a child who is born seemingly healthy but dies within a few hours or days due to external causes, can still be called a *fausse couche*. ‘You didn’t deliver normally, did you? The child has passed anyway’ was their rhetorical answer to my initial confusion. Thus, different losses that carry the biomedical labels of perinatal, early and late neonatal deaths are all called ‘wrong deliveries’ (*fausse couches*) in French or ‘passing children’ (*mon ia nul*) in Gbigbil; what counts is that the (developing) *mon* finally ‘passed by’ – whatever the specific moment and cause of loss.

This is not to say that these losses are not *experienced* differently by mothers. Women indicate a great difference between the loss of a *mon* that is still in the uterus and the decease of a *mon* that one has seen alive upon birth. They express their experiences mostly in terms of visibility of the child’s humanness – its forms and force. Thus, the expulsion of *zəŋ mon* is often minimized since it does not yet show any human features. Likewise, the loss of a *mon* who died ‘before its time’ is relatively bearable because its
dead and forceless body is immediately taken out of sight and buried without much publicity. Yet, the death of a child that was born well-formed and full of force, and that has been cared for and given a name, is heavily regretted and remembered.

Preoccupations with force and forms surface yet in another way: next to foetal physicalities, women also focus on their own bodily states after ‘wasted pregnancies’ and ‘wrong deliveries’.

**Fighting with force: Losses lamented**

When evaluating the impact of reproductive mishaps, Gbigbil women agree that pregnancy losses always have more severe consequences for their bodily wellbeing than normal deliveries do. Whether happening in the early or later stages of gestation, aborted pregnancies imply a diminution in blood and force that is dramatic as compared to the loss occurring during childbirth. Women distinguish between the loss of zəng mon and the loss of mon as to the manner in which these vital substances are lost. In case a pregnancy ‘falls’ in the initial phase of development, what is considered harmful is the abundant loss of blood – not only the blood of which zəng mon is constituted, but also the maternal blood that is perceived to surround and nourish it – which causes a direct depletion of a body’s force reservoir. Charlotte explains:

> In case of an early abortion, the substance of the child is removed from your own body with force! It was stuck to you and now it leaves. You lose a lot of blood because you are wounded inside – both before the foetus leaves and
afterwards. Some women even faint. They have no blood left. No force in their bodies anymore.

A woman’s force is indirectly decreased during ‘wrong deliveries’ that happen after a human-like mon has been formed. In these cases, loss of ngul becomes inherently related to the decreased force of the baby. For, a child who is delivered ‘before its time’ does not have the appropriate amount of force to initiate and manage childbirth, gets ‘tired’ quickly and is likely to die from ‘fatigue’. This, in turn, poses increasing demands on the force reservoir of the pregnant woman who should now finalize the ‘wrong delivery’ with her own strength; without any incentive from the dead foetus, an enormous amount of maternal force is wasted in the process. It happened to the 17-year-old Michelle, who delivered a stillborn son with the help of her mother and a midwife. She says:

They forced to get the child out, but it was very difficult. Since the child was already dead, he could not get out by himself. So they had to push my belly, so that the child would take the right direction. The midwife inserted her hand and hooked her fingers to pull the child out. At least, that’s what people tell me, since I was already…I don’t know. I was already tired, I could not even scream anymore. It was not even what they call fatigue huh? I was already dead.

If a woman’s reservoir of strength is already depleted due to multiple previous pregnancies or, more devastatingly, their disruptions, the maternal body can become too
poor in blood and force to compensate for the lack of foetal force and succumb as a result. Aware of the dangers of weakness in their babies’ and their own bodies, women apply several methods to optimize force levels in both. As they consider foetal development a contingent and unknowable, rather than an a-priori fixed, trajectory, women constantly attempt to accelerate the formation and ‘force filling’ during pregnancy. Through the consumption of nutritious food, different physical activities and regular sexual intercourse with the child’s father (whose semen is considered a substantial source of foetal nourishment), they hope to quickly install a level of force that would allow for the child’s survival upon expulsion. Towards the end of pregnancy, women also apply remedies to open the ‘passage way’ during childbirth and prevent a fatal wastage of energy while the foetus ‘forces its way out’. The quicker a delivery happens, the more the force reservoirs of mother and child can be spared.

After both successful and – especially – ‘wrong’ deliveries, Gbigbil women feel the need to replenish their blood and force levels so as to stay ‘in form’. For, gradual depletion of the blood reservoir is associated with growing old and weak and thereby becoming less resistant during future reproductive events. Even if they deem it impossible to get back to previous levels of blood volume and strength once a loss has occurred, women deploy several methods to at least partially restore the amount of blood and force in their bodies. They consume green leaves, drink concoctions containing papaya, milk, red wine or mashed tomatoes – supposed substitutes of blood – and search for biomedical injections, which, entering the veins directly, would offer the quickest boost of energy. To be ‘in form’ is important for Gbigbil women, whose lives are often
characterized by a chain of pregnancies – the development and dangers of which are directly related to one’s amount of blood and force.

Reproductive loss reinterpreted

This phrasing of the development and dangers of pregnancies in terms of blood strength reveals a completely different view on pregnancy, loss, and reproductive risk than the one portrayed in biomedical international discussions. Indeed, foetal age, maternal age, and delivery duration – three important foci of global concern – seem to acquire different meanings and become based on other criteria than linear time in eastern Cameroon. Even if the gradual development of zɔŋ mon into mon may seem as linear as biomedical embryological models, this process cannot be traced to fixed time patterns but is variable and contingent upon the quantity and quality of the parents’ blood. Likewise, the physical degeneration that underlies women’s ageing process depends not on the passage of years but on the strength of carried foetuses, determining how much blood and force women will waste during deliveries. Finally, what matters in ‘wrong’ deliveries is not that time is passing but that foetal force and maternal blood are being lost. The crux of reproductive loss thus seems to be the force and forms of mother and (zɔŋ) mon, which are inherently intertwined – yet in a way that is undefined and by definition unknowable.

This indeterminacy around embryology and maternity leaves room for all sorts of manipulations around pregnancy and loss. Since the boundary between the loss of a ‘pregnancy’ and the loss of a ‘child’ is fluid and ambiguous, women can, especially when disruption happens in the beginning of a pregnancy, strategically appoint what is actually lost – mere ‘blood’ or a ‘child’. The fluidity of foetal development thus offers women a
rich terrain for negotiating the beginnings and endings of human life (Kaufman and Morgan 2005) through which they can downplay or dramatize their reproductive mishaps within the given circumstances. Gbigbil women may want to downplay a loss if the event triggered suspicions of induced abortion or caused upheaval within the family(-in-law) that threatens a marital future or other personal goals; they may want to dramatize it if the self-depiction as a ‘sufferer’ is likely to lead to increased attention, care, and favourable options or future imaginations.2

Similarly, women negotiate the fate of their own reproductive lives after pregnancy loss through an explicit focus on their physical force and forms; those who want to postpone childbearing claim to be too low on force or not yet ‘in form’ after the previous mishap, while those who are eager to conceive again make explicit efforts to replenish their blood reserves. The fluidity of force levels – of both foetus and mother – thus allows for many possible interpretations of and reactions to reproductive loss in eastern Cameroon. Such experiences could not be completely captured if the fixed biomedical framework would be taken as the only valid reference point to study women’s reproductive reasoning.

This is of course not to say that Gbigbil women do not know the biomedical framework or use its health services at all. Interestingly, they may resort to biomedical time-based models that seem at odds with Gbigbil embryological notions if these serve their reproductive negotiations and justifications – like when temporal understandings of ‘viability’ or ‘prematurity’ are used to strengthen one’s downplaying or dramatization of a particular loss. Practically, biomedical services – especially injections – are explicitly

2 Likewise, women often strategically adjust their aetiological explanations of pregnancy loss; their ideas on what has caused a particular loss may vary along with their specific social situations (Van der Sijpt 2010, Van der Sijpt and Notermans 2010).
sought in the process of replenishment after reproductive mishaps. Exactly because local notions of foetal and maternal health foreground variability, indeterminacy and personal particularity, they – almost paradoxically – allow for the pragmatic inclusion of biomedical categories and care whenever these seem relevant. The medical model then forms just one of the many possible interpretations favoured by a flexible framework focusing on force and forms. Thus, in this eastern Cameroonian village, it is not the biomedical framework that necessarily defines reproductive events, but the other way around: the reproductive events – the social situations and individual stakes around pregnancy loss – define the necessity and relevance of biomedical time-based models for my Gbigbil informants.

References


