'Spirit Children'

Care, Uncertainty and 'Infanticide'

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Link to publication

REVIEW ESSAYS

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Keywords

The Human Relations Area Files (HRAF), half a century ago a popular database for comparing and counting cultural traits and practices in more than 200 societies, tells us that infanticide occurred in the majority of cultures worldwide. This conclusion is based on information that was gleaned from brief statements published in anthropological and historical publications without much context or ethnographic nuance. Aaron Denham (2017), in his excellent study of infanticide among the Nankani people in northern Ghana, acknowledges the common occurrence of infanticide but wonders 'where the people [i.e., those who are reported to have practised it] are'. In fact, experience-near ethnographic research into the thoughts, emotions, and practices regarding infanticide is nowhere to be found. It is not difficult to guess why this is the case. Infanticide is a sensitive topic about which people may not be willing to speak. Moreover, its practice is regarded as exotic and sensational by the outside world, and a researcher is likely to get mixed up in ethical muddles when entering the precarious field of families involved in the killing of infants and young children. When Denham asked a colleague

anthropologist why she had not developed her observations of infanticide in her published work, she answered that she had wanted to protect the people from being stereotyped (as 'savages', I assume).

During my own research about birth control practices in a rural town in the southern part of Ghana—which occurred 50 years ago—I was also told about infanticide in the past. People told me that a deformed child was killed immediately after birth by drowning it in a bucket of water. People would refer to it with euphemisms such as 'the child was born and has returned' or 'the child did not become well'. Those who spoke to me did not agree on the types of deformity that prompted infanticide, but all mentioned the child with six fingers on one hand; such a child was believed to bring misfortune to the family. Other deformities included a cleft lip or palate and hermaphroditism (Bleek 1976, 190–191). These are typical examples of the kind of data that Denham criticises—without providing context or indeed a trace of human emotion—in the introduction of his book.

Denham's approach is an impressive attempt not only to produce a detailed, thick ethnography but also to humanise the practice and to connect his readers with the experiences of people who struggle with questions of life or death with regards to children who are considered unfit for living. Connecting his readers to such experiences is achieved through his own connecting. He accompanied fieldworkers from a local NGO, AfriKids, which tries to help vulnerable families in northern Ghana, including families with a so-called 'spirit child' (see next paragraph), and which thus became directly involved in the struggles and uncertainties of these families. The NGO was not seen by the researcher as an interfering agent to be critically observed, but as a 'vehicle' for getting closer. Moreover, he saw the NGO as one of the many forces that shape the spirit child phenomenon.

Spirit children in Nankani families are children who are believed to be evil spirits in human forms. It is assumed that they have entered the family to cause misfortune. The symptoms used to identify a spirit child are physical signs of illness and bodily abnormality, as well as particular strange behaviours. Stories abound of relatives who have seen such a child doing evil things in the night, but more common observations are physical deformities, not eating, the inability to walk, and incessant crying (also at night). The cosmology behind these phenomena lies in the distinction between 'the house' and 'the bush'. The house is the safe area for living people and ancestors, while the bush is the space of evil spirits. Passing through the bush is dangerous; a spirit may jump on or enter into a passing person and thus sneak into the house in the form of a spirit child that will be born some time later.

The birth of all children is thus initially met with some anxiety and, when suspicious symptoms present themselves, uncertainty and ambivalence increase. This may eventually lead parents to consult a diviner and later a concoction man able to confirm whether or not the child is a spirit that needs to be removed before it causes more harm. The concoction man applies a medicine that will prove the true identity of the child. If the child survives, it is not a spirit child.

The process of decision making is, however, less 'rational' and straightforward than suggested in the previous paragraph. If bystanders are convinced that the child *is* a spirit (i.e., not a human being), then the proof may be repeated several times. Family members may also disagree; mothers in particular may do everything to keep the child away from the concoction man, and NGO workers may suggest other solutions. Money too plays a crucial role. The costs of treatment in a clinic or hospital may be far beyond what a family can pay.

The various case histories that Denham presents throughout his book offer heartrending insights into the dilemmas and despair that these families encounter. These stories are the most telling part of his ethnography; all are cases in which the author was involved, not as a distant observer, but as a participant in search of a humane solution. Let me summarise one example (drawn from pages 148–152):

> Samuel was his parents' third child. Their first child had died shortly after birth, the second, a girl, was twelve years old. From the time of his birth, Samuel had been a sickly and weak child. At first, a senior relative with a job as a public servant had helped Samuel's parents pay for his many medical treatments, but the support had stopped when he could no longer afford to help. This relative had then suggested that Samuel may be a spirit child because the boy's condition did not improve at all, despite treatment. For the parents, it became increasingly difficult to meet Samuel's and their own needs. Samuel's health report showed that in the first six months of his life he had been taken to the clinic five times because of malaria, pains, incessant crying, fever, vomiting and coughing. The diagnosis of cerebral palsy was made when he was about one and a half. In the same period as the diagnosis, the parents had taken Samuel to a healer in Burkina Faso, without any results. Suspicions that Samuel was a spirit child came and went. His parents could not make up their minds. They remembered that the mother, on her way to the clinic during her pregnancy, had rested for a while under a baobab tree and had picked a fruit to eat. She had not known that it was a place where spirit children used to be buried. That was probably the moment she was given a spirit child, they thought.

The mother lamented: 'I cannot go anywhere to work'. The child tied her to the house. A spirit child means not only suffering, but also poverty. The couple wanted to have another child, but that would not be possible under the current circumstances. Denham visited the family every few weeks. His fieldnotes contain extensive descriptions of Samuel's symptoms and his parents' struggle. AfriKids tried to find a residential home for the boy, but the parents could not afford it. Denham writes: '… it was hard not to reflect on the notion that death would be a welcome release for all … We wondered whether it would be more humane if the family still viewed him as a spirit child and gave him a concoction'. The father: 'It isn't easy. You know this child will not be able to do anything on this earth'. And the AfriKid fieldworker: 'Really, the child is suffering. The family want to set him free'. Eventually, Samuel died at the age of five, probably from malaria or an infection. The same day, Denham received the news that the mother was pregnant.

In his introduction, Denham remarks that the reader may ultimately 'recognize that the experiences and decisions around spirit children might not be as distant as they seem' (10). Towards the end of his book, he directs the reader to consider discussions about euthanasia and infanticide in Western societies. The conclusion is unavoidable: what was stereotyped as a feature of 'primitive' poor people in the past turns out to be an extremely hot topic today in affluent and 'highly developed' societies where advanced medical technology is available. Abortion and amniocentesis to avoid birthing disabled children (Benn 2009; Ville 2011) and euthanasia in its various modalities fill the daily papers and academic journals of my own society (the Netherlands) and elsewhere. Paradoxically, the 'problem' of euthanasia and infanticide is not the result of poverty and/or a lack of medical facilities, but, rather, the opposite: questions about the undesired prolongation of life and unnecessary suffering are produced by the successes of our medical system.

In Belgium and the Netherlands, resistance to medical technology's grip over how and when we end our lives is strong and only growing stronger. A large majority of the Dutch population supported the legitimisation of euthanasia in 2002 (Kennedy 2002). Interestingly, a growing number of medical professionals also acknowledge the paradox of the undesired prolongation of life and thus support euthanasia under certain conditions: there must be unbearable suffering without prospect of improvement and an explicit, voluntary, and well-considered request from the patient, who is competent to express his/her will. Since this turning point in 2002, a large majority of the people who have received euthanasia have been cancer patients in the final stages of the disease (about 65%). More recently, however, the public debate has changed and now focuses on other, more complex cases that should (or should not) be eligible for euthanasia requests. These include

patients who suffer from severe mental health problems, people who have advanced dementia, terminally ill children, and older people who, though they do not suffer from any somatic or mental illness, consider their lives 'completed' (Evenblij et al. 2019; Van Wijngaarden et al. 2020). In the case of those requesting euthanasia based on a 'completed life', there is doubt about the criterion of 'unbearable suffering'. For the other three complex cases, there are strong doubts about the 'well-considered request from the patient'. Public opinion is, nevertheless, slowly moving towards greater support for an extension of the euthanasia rules. In today's Ghana, this widespread approval of all kinds of euthanasia practices in a 'civilised' society is met with disbelief and shock (Van der Geest 2009)—a good reason to bring the Dutch and Ghanaian cases together for critical comparison. Prompted by Denham's empathic description of the uncertainty and suffering of parents of spirit children in Ghana, I turn to Eric Vermeulen's 2001 (in Dutch) ethnography of two neonatal wards in Belgium and the Netherlands.

Prematurely born children in the Dutch neonatal ward are considered potentially viable from the age of 26 weeks (a normal pregnancy lasts 40 weeks), meaning highly technical treatment is started even though doctors and nurses are uncertain whether the children will make it. Children born under 26 weeks of gestation have to show that they are viable before full intensive care is started; thus, at first, they receive only supportive care. Doctors are aware that their interventions may keep a child alive, but at a terrible cost: the child may become severely disabled. In some cases, they wait and observe the child to see whether it is a 'fighter' (i.e., whether treatment is likely to be effective). During the three to five (or more) months of treatment, there is constant discussion and testing to appraise the chances of a favourable outcome. The period in which a child is dependent on life-supporting intensive care treatments is a time frame in which it is possible to make a decision about the life of the child. If the future of the child is considered highly compromised because of brain damage, the treatment can be stopped without legal consequences. This is discussed with the parents (because it is often also a question of 'quality of life' estimations, the opinion of the parents is very important).

What happens at the Dutch neonatal ward may seem the opposite of the practices described by Denham in northern Ghana. But Vermeulen (2001) points out that stopping intensive care treatments with the goal of ending the life of a child follows the pattern of infanticide as described in some cultures. Like the newborn that is only given a name after seven days (and thus accepted as human), the child on the ventilator is in a liminal position; making life and death decisions is only possible during this limited period. In part, this is due to legislation. If a newborn is no longer dependent on respiratory therapy and can breathe by itself, then ending the life of this child would require an 'active' (medicinal) intervention. That active

life-shortening intervention should be reported and would then lead to legal investigation. The physicians wanted to avoid this and therefore chose to make such decisions in the time the child was dependent on respiratory therapy. The reason for such action is to prevent the child from unbearable future suffering due to severe disability. It is an act of mercy to the child, but also to the parents, although the latter are mentioned far less often.

The same struggle for the survival of a child that Vermeulen described in Belgian and Dutch neonatal wards also took place in the Ghanaian homesteads that Denham visited—sometimes with success, sometimes not. Underlying the apparent differences in terms of culture, medical facilities, and socio-economic contexts is the striking similarity of the human concern shown regarding the fragility of just-born babies with uncertain futures. Throughout his voluminous study, Vermeulen presents 12 extensive cases of children (one more than 40 pages long) that remind me of the cases in Denham's book. I summarise one of them very briefly below:

> 'Irma' was a 26-week-old baby girl who was born very ill but was found to be treatable. For a month, every effort was made to keep her alive and the parents were deeply involved in the treatment, hoping that she would make it. Then it turned out that Irma had suffered serious brain damage, partly as a result of what she had experienced in utero. The parents did not want to inflict a life on Irma that they at that moment considered 'unliveable' and thus they decided, in consultation with the medical team, to discontinue the intensive treatment. The sad outcome was the death of a highly-desired child. The parents and the medical team did not regard this as infanticide, but saw it as the consequence of an incorrect decision to pursue medical interventions.[1]

The similarities of the two cases—of Irma in the Netherlands and Samuel in Ghana—are striking despite the extremely different social and cultural circumstances. In both, care (sometimes hopeful, sometimes desperate) and uncertainty dominate the vicissitudes of the child's condition. In both, the actors involved strive for a humane decision and an end to the child's suffering. After the ultimate decision has been taken, they feel relieved in spite of their sadness: they have 'set the child free'. The main significant difference between the two is that the Ghanaian couple could not afford the costs of further treatment, while the health insurance of the Dutch couple had taken care of their enormous costs.

The consequences of not allowing euthanasia at the beginning of life are incomparably bigger than disallowing it at the end of life. Yet discussions about

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[1]   A longer English version of the case can be found in Vermeulen's (2004) English publication in *Social Science & Medicine*.

euthanasia are mostly about the voluntary deaths of older people. The suffering that is caused by keeping alive a child that would have died without medical intervention is in no way proportional to the distress that professionals would inflict on older people if they denied them the good deaths they ask for; the forced prolonging of unnecessary suffering at the end of life pales in comparison to the tragedy of lifelong misery for the newborn, its parents, and other relatives. Doctors know that they should be cautious and temper their medical expertise and 'heroism' to avoid such harm. One wrong decision in this crucial phase may lead to many years of regret and suffering.

Aaron Denham's description of the hardship of spirit children and their parents in northern Ghana is an impressive example of what anthropology could (and perhaps should) do: it provides the stuff necessary to rethink the taken-for-granted status of our own cultural beliefs, however remote and different the circumstances of our societies may be.

A final remark about terminology. The term 'infanticide', like 'suicide', has attached to it an unspoken negative judgement and does not do justice to the positivity of the emotions and care that it implies. No doctor, nurse, or parent in the Dutch neonatal ward would call what they do 'infanticide' and they would be upset if others did so. The term has fallen victim to the ethnocentrism with which people of different cultures judge each other. If in all cultures where 'infanticide' occurs the practice is euphemised, why should we refer to the act of killing children—'here' or 'elsewhere'—without cultural understanding or compassion? The term is emotionally related to 'homicide' and even 'genocide', and mainly evokes moral aversion. By calling the euthanasia of children who have no chance of living a bearable human life 'infanticide', we create a phenomenon that is typical of 'others', but not of ourselves.

About the author

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