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**DOI**

[10.1111/j.1548-1387.2010.01110.x](https://doi.org/10.1111/j.1548-1387.2010.01110.x)

**Publication date**

2010

**Document Version**

Final published version

**Published in**

Medical Anthropology Quarterly

[Link to publication](#)

**Citation for published version (APA):**

van der Sijpt, E., & Notermans, C. (2010). Perils to pregnancies: on social sorrows and strategies surrounding pregnancy loss in Cameroon. *Medical Anthropology Quarterly*, 24(3), 381-398. <https://doi.org/10.1111/j.1548-1387.2010.01110.x>

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## Perils to Pregnancies:

On Social Sorrows and Strategies Surrounding Pregnancy Loss in Cameroon

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*This article explores the local perceptions and practices surrounding pregnancy loss in Cameroon—a topic that has long been neglected in international reproductive health debates. Based on extended periods of anthropological fieldwork in an urban and a rural setting in the East province of the country, it shows the inherent ambiguities that underlie pregnancies and their perceived dangers. By situating meanings of pregnancy loss within the complex dynamics of marriage and kinship, pregnant bodies are argued to be social bodies—the actions and interpretations of which shift along with social situations. This approach not only forms an alternative to the current focus on the body politic in global discourses on fertility risks but also shows how conventional assumptions such as the rigid distinction between voluntary and involuntary pregnancy loss distort ambiguous daily life realities for Cameroonian women whose pregnancies are not being carried to term.*

Keywords: [pregnancy, risk assessment, miscarriage, abortion, Cameroon]

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From the 1950s onward, there has been much international and scholarly attention for, on the one hand, overpopulation or high fertility rates in African countries; and, on the other hand, experiences of infertility in these so-called pronatalist cultures. Many studies have investigated the ideological values, economic costs, and social benefits of having many children in African settings, as well as the stigmatization and material deprivation of women who are not able to live up to this ideal.<sup>1</sup> Because of this attention to both extremes on the fertility continuum—either high fertility or infertility—for a long time relatively little light has been shed on the situation of women experiencing the “in-between” situation of reproductive loss—being able to conceive, but not carrying their pregnancies to term.<sup>2</sup> Yet pregnancy loss is a recurrent phenomenon: although rates of pregnancy loss are not universal and vary per locality, general estimations suppose that at least 15 percent of all clinically recognized pregnancies spontaneously end in a miscarriage, and that approximately one in 50 fetuses are stillborn worldwide (Rai and

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MEDICAL ANTHROPOLOGY QUARTERLY, Vol. 24, Issue 3, pp. 381–398, ISSN 0745-5194, online ISSN 1548-1387. © 2010 by the American Anthropological Association. All rights reserved. DOI: 10.1111/j.1548-1387.2010.01110.x

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Regan 2006; Regan and Rai 2000; WHO 2007).<sup>3</sup> To this, conscious efforts to terminate pregnancies should be added. Furthermore, whatever the specific loss rates in different localities, there is a general agreement that the chances of spontaneously aborting a pregnancy increase with age and that one loss increases the risk of losing subsequent pregnancies (Brigham et al. 1999; Clifford et al. 1997). Thus, especially when carrying multiple pregnancies during a life course, women are very likely to experience some form of loss at least once in their reproductive trajectories.

Although during the last decade there has been increasing acknowledgment of the frequent occurrence of these reproductive disruptions, international attention to the problem is rather one-sided—with more attention to induced than spontaneous loss—and overshadowed by other pregnancy-related issues that are considered more pressing—for instance, the prevention of unwanted pregnancies or maternal and infant mortality. Most significant in this respect are the World Health Organization's Safe Motherhood Initiative of 1987 and the Post Abortion Care strategies since 1993. Both enterprises problematize and medicalize pregnancy and childbirth by focusing on the life-threatening risks of excessive fertility and complications resulting from unsafe deliveries and abortions. Key strategies for reduction of these risks include the monitoring of pregnant women before birth and providing family planning services afterward. In this attempt to regulate, survey, and control women's reproduction, the pregnant body has become a body politic (Casper 1998; Martin 1987; Scheper-Hughes and Lock 1987). These politics surely have made pregnancy loss more visible and recognized as one amongst many other complications related to maternity; however, the health establishment's inherent attention to physical problems and management procedures leads to a mere medicalization of the experience of reproductive mishaps. Personal experiences, if alluded to, become represented through homogenized, objectified "hypothetical women" undergoing either induced or spontaneous abortions—presented as two different typical "cases." Overall, a rather technical story prevails (Allen 2002).

Yet, pregnancy loss concerns a phenomenon that is crucial to women's daily social lives as well; there are many personal stories behind it. Since the 1990s, these stories have become more and more investigated by medical anthropologists aiming to "give voice" to marginalized groups or events that had too long been silenced in normative or technical accounts of reproduction. These anthropologists seek to contextualize and diversify the unheard voices talking about subjective experiences of reproductive loss in different cultural settings.<sup>4</sup> They show how the event inherently relates to social affairs such as illness, pain and suffering, marriage and kinship, the body and personhood, or death and mourning. This article aims to contribute to this growing body of medical anthropological literature by focusing on the social aspects of pregnancy and pregnancy loss in women's daily lives in Cameroon. Considering pregnant bodies as social bodies, it will situate local practices and perceptions with regard to pregnancies and their experienced difficulties within the existing contexts of marriage and kinship—and their inherent contradictions and ambiguities. The sociocultural insights on perceived fertility stakes and dangers will then be related to the international debates on risk where pregnant bodies have been predominantly homogenized, politicized, and medicalized.

## Study Design and Methods

The insights presented in this article were developed on the basis of long-term anthropological fieldwork in both a rural and an urban area in the East province of Cameroon. Ethnographic data collected in the rural setting, over a period of 15 months between 2004 and 2009, will be used to illustrate these insights. Compared to other settlements in the rain forest area, this village is rather large, with the presence of approximately 1,000 inhabitants as well as different Christian churches, a kindergarten, a primary and secondary school, and a health center with a maternity ward. Most of the data were gathered through participant-observation, which in this specific context implied accompanying women to their fields, caring for their children, cooking and eating together, participating during their deliveries and abortions, or visiting the market, church, hospitals, and healers with them. Next to the informal conversations that took place during these daily events, formal in-depth interviews were held in French with 25 informants. This group included women from all age groups, with different educational histories, economic backgrounds, marital statuses, and reproductive experiences—the latter covering primary and secondary infertility, losses during various stages of pregnancy and in the neonatal period, as well as both successful and unsuccessful abortion attempts.

The interviews with this varied group of women centered on specific themes, such as embryology, sexuality, marriage, kinship, witchcraft, religion, and matters of life and death. Further, repeated life-history interviews were held with 13 women. Several rapid appraisal techniques, such as focus group discussions, body mapping, free listing, and pile sorting were used to explore local conceptions of embryology and etiology. These notions, among many others, were also explored and given quantitative and qualitative substance during a reproductive health survey, which reported the reproductive histories of 287 village women who were (or had been) sexually active. This multiplicity of methods yielded detailed information that allowed for a thorough exploration of the complexity and diversity of pregnancy loss. All interviews, focus group discussions, and body-mapping sessions were recorded and transcribed verbatim in French.<sup>5</sup> The life-history interviews were coded in ATLAS.ti for systematic content analysis.

## From the Anonymous Body Politic to the Ambiguous Social Body

Within international reproductive health debates, representations of pregnancy loss often remain abstract and oversimplified. Whether through numbers, medical jargon, or stories of anonymous “hypothetical women,” there is a tendency to create a general, universally applicable picture of reproductive disruptions. However, especially medical anthropologists have been eager to stress the influence of local social contexts and culturally mediated perceptions on reproductive health and behavior. Many thereby agree with the insights of Schepers-Hughes and Lock (1987), who, by deconstructing a rigid body–mind dichotomy, have argued for a more detailed analysis of the body and its inherent relation with the surrounding contexts. Rather than viewing the body as a bounded physical entity serving as the basis for individuality, the authors indicate that the body should be seen as a unitary, integrated aspect

of self and social relations—a social body. This idea of a social body has implications for both people’s interpretations of health and illness—with social relations often considered key contributors to individual experiences—and their health seeking behavior, which might be directed toward collectivized and socially embedded therapies rather than biomedical models relying on individualist notions of physical health (de Rosny 2004; Kleinman 1988; Scheper-Hughes and Lock 1987).<sup>6</sup>

With regard to pregnancy loss, we argue that pregnant women could be viewed as having social bodies, made up by and inherently interwoven with their social relationships, especially in the fields of gender, marriage, and kinship. Not only is pregnancy the utmost manifestation of a woman’s relationships with a man and a child, but it also symbolizes wider kinship and marital relations—a pregnancy constituting the link between ancestors and future generations within a certain family, as well as between different extended families. This relational perception of social reality in general and of the pregnant body in particular affects how people cope with and give meaning to (risks of) disruptions during pregnancy. Acknowledgment of the inherent sociality of pregnant bodies thus enables us to understand reproductive notions and decisions surrounding pregnancy and loss more comprehensively than the global focus on the body politic and the individual body allows for; it shows what is socially at stake for pregnant women.

Considering the complex dynamics of the social fabric, we further contend that these stakes are constantly changing. Situating pregnancies and their losses within surrounding marital and kinship arrangements—which are pervaded by ambiguity as a consequence of multiple, often contradictory, norms and practices—provides insight on how meanings of pregnancy loss are not only socially constituted, but with it also highly dynamic. Only careful investigation of personal stories and social situations can show how etiologies and risk perceptions are not only more encompassing than biomedical individualist explanations of pregnancy loss but also strategically applied in ambivalent atmospheres. In the following, we will shed light on these ambiguities, and we will describe socially relevant contexts of reproduction and the way these are implicated in women’s shifting perceptions about having, protecting, losing, or aborting their pregnancies.

### Reproductive Ambiguities and Ambitions

In East Cameroon, daily activities in general and relationships between men and women in particular are profoundly shaped by marriage and kinship settings—two domains of life that are dynamically related to each other. Ideally, marriage (*abal*) is considered to be an affair of families rather than individual partners. A conjugal arrangement should be concluded “traditionally” through a series of exchanges between both partners’ families, whereupon the woman sets out to live with her new husband (*num*) and his relatives (*mekil*). With the continuation of bride-price payments to the family of the woman, every child borne in this marriage should be considered as belonging to the father and his family. Even when a woman would decide to leave her husband and to go back to her own family, her children are supposed to stay within this patrilineage.

In such a setting, as has been noted for many other patrilineal societies as well (Bonnet 1988; de The 1970; Geschiere 1982), the position of a (newly) married

woman has always been pervaded by ambivalence: for the family of the man, she is an outsider on whom they depend for the continuation of their lineage; for her own family, she eventually becomes an outsider as well because she will leave her paternal home to go and bear children for another family. A local saying tellingly indicates that daughters are to be “shared” (*mon munko ane komaka*). Never really “belonging” somewhere, married women are in an ambivalent position, fraught with frictions—feelings of hostility and solidarity—toward both families (Geschiere 1982). Descendants are at stake for both parties; the pregnancy of every woman—herself being a descendant of one family but bearing descendants for the other—is a site of contestation. Consequently, childbearing becomes conceptualized as one side of a reciprocal relationship; in return, a woman’s family might ask several gifts, services, and bride-price payments to compensate for the loss of their daughter and her childbearing capacities—thereby creating an enduring alliance between the two lineages.

However, people point out that this payment of (parts of) the bride-price (*ivoula*) is in practice often retarded or left out completely. Of the 174 surveyed women who considered themselves to be married, only 31 percent of them declared that the complete bride-price had been paid. Consequently, many marriages—particularly those of young people—are no more than informal arrangements constituted by the living, eating, and sleeping together of a man and a woman. Time is taken by both partners to explore each other’s worth: women want to be ensured of the good character and (financial) responsibilities of a man before settling down in his family, whereas men wait for a proof of women’s fertility before engaging more formally. These informal unions, in which bride-price payments are not yet or hardly initiated, are easily dissolved as soon as one of the partners loses interest; it only entails the returning of a woman to her own family again. Thus, marriage arrangements are fragile and flexible and offer some freedom to women and men alike (Notermans 2004). Not surprisingly, unions concluded at the municipality or in the Christian churches—formally restricting this marital freedom—are rare; among the group of married women, only 56 had signed a marriage act and only 21 of them had continued the ceremonies in a church. Men especially seem hesitant to deprive themselves of the possibility of taking another wife in the future because polygyny is a widespread practice in the region—much to the lamentation of women, who indicate that relations between cowives are often pervaded by jealousy and conflicts.

Within this insecure marriage setting, bearing children is an important strategy for women to prove their fertility and, thus, convince their partners of their worth, the possible rewards of engaging, and the necessity to initiate negotiations between families. At the same time, many women complain that they “constantly bear children without our families eating anything,” thereby indicating that the ideal reciprocal relationships between alliances are in practice absent or unequal: although their pregnancies secure the future of the husband and his family, it leaves their own families rather insecure—losing “their person” but not seeing something in return. Inheritance, therefore, is often heavily contested with maternal families trying to claim the children of their daughters in certain circumstances (Notermans 2004).<sup>7</sup> Indeed, of 287 surveyed women, 34 percent stated that, contrary to what norms prescribe, their child(ren) resided within their maternal rather than paternal families. Kin relations, like conjugal relationships in the village, are thus characterized

by complexity, flexibility, and fluid interactions between norms and practices; pregnancies are surrounded by multiple interests, values, and strategies.

It is within these social contexts, where expectations and realities stand in an ambiguous relationship, that we should understand people's perceptions of what is at stake during pregnancies and how these stakes can possibly become endangered. In the following, we will describe local practices and notions surrounding reproductive disruptions and highlight the social complexities surrounding motherhood, childbearing, and loss—social complexities that are largely overlooked by technical medicalized accounts in the global health arena.

### From Worms to Witchcraft: Sophie's Story

The 27-year-old Sophie met her current husband ten years ago when she had already borne a daughter with another man, whose marriage proposal she had declined because the man was already married and she refused to enter as a second wife in a polygynous marriage. Seeing the proof of her fertility, her husband got interested in her. As he really longed for children—being the only son of his mother and having married several infertile women before he met Sophie, so having no descendants whatsoever—he and his parents quickly transferred the traditional gifts to her family as soon as Sophie got pregnant. Sophie, however, considered herself too young to bear a second child and wanted to finish her education first. When she unsuccessfully tried to abort the unexpected pregnancy, her new husband convinced her to keep the pregnancy and promised her a good future. And so it was—at least, initially. The couple lived a relatively stable life in the city, as Sophie's husband had an official job and, thus, some regular income. Soon after she weaned her second daughter, Sophie got pregnant again but miscarried after two months. She tells:

My first miscarriage was caused by the women's worm that often picks in the lower abdomen. It started picking me when I was pregnant for two months. When I wanted to urinate, I saw spots of blood. Although my aunt had given me some bark [of a medicinal tree] to stop the bleeding, it did not help. Because the worm was alive. I should first kill him. It is the mectizan medications that have treated this for me.<sup>8</sup> I went to the hospital to ask if the mectizan that we should take would only kill simple worms. They told me that it even kills the women's worm. When I heard this I decided to take it. And it killed the worm. The same month, I got pregnant again. My husband and in-laws were angry when they heard that I miscarried. They said that maybe it was me who had tried to abort this pregnancy. I told them, "no, of course I know the methods, but I could never do that. It is not me, it is a worm." And then they saw it themselves, since I got pregnant immediately.

As Sophie quickly succeeded in conceiving a new pregnancy, her miscarriage was soon disregarded: the cause had been determined and cured and "people didn't consider it too much, since it was a pregnancy of two months which contains only water." As bride-price transactions continued, Sophie's family members and friends convinced her to resign herself to the fact that she was now a married woman and, thus, expected to bear children. And so she did; she gave birth to her third

daughter, and the couple even had plans to marry officially. It was during her fourth pregnancy, however, that “everything got spoiled” because of an extramarital affair of her husband. Not only was he now absent most of the time, but he also neglected his financial responsibilities toward Sophie and her children and even denied being the father of her current pregnancy. Seeing no positive prospects whatsoever and thinking of the burden of her three daughters, Sophie tried to abort this pregnancy but failed again. Moreover, she was heavily discouraged by her mother, who found out about her abortion attempts. She finally gave birth to a fourth daughter, just at the moment when her new cowife moved into the house.

From this time onward, the many fights between the cowives made the situation unbearable for Sophie. She ran away and took refuge with her mother and sisters in the village. They allowed Sophie the space to “get rest” in these times of conjugal distress but at the same time insisted on her eventual return to the marriage. “Since there were already children, they said it was not good to leave them behind like that.” Sophie thus foresaw an unpreventable return to her husband and secretly started taking contraceptive injections. However, when she forgot to attend a follow-up consult for contraception, she got pregnant again. Within this context of conjugal turmoil and frustration, Sophie experienced another miscarriage, about which she tells:

It started with pain in my back, around the kidneys. It got really warm. The warmth reached my uterus. I went outside because I thought I wanted to urinate. When I squatted, a ball of blood fell down. I stayed for at least thirty minutes in the WC because the blood was flowing. Then, I stood up, went to the house and changed my clothes. In all this, my husband was there. But he neglected me, as always. I suffered a lot afterwards. I could only lie down. It hurts a lot and you bleed a lot as well. So my husband told me, “take this money and go to the hospital for injections.” But after this, my husband didn’t say anything anymore. I often asked him, “What could be the cause of all this? I do not even work hard like the women in the village because we are in the city. So what is it?” Doctors say I suffer from typhoid. But even now that I am under treatment for this typhoid, my belly is very warm inside. Why doesn’t it go away if I take the proper medicines? And look, when I am here in the village, far from my husband and that woman, the situation tends to ameliorate. But when I get back to the city, to my house, problems worsen again. I will never enter that house again as long as that woman resides there. She is a witch wanting to destroy my children. I will not bear children anymore.

A comparison of these two incidences of loss shows not only how Sophie’s experiences and interpretations of loss drastically changed but also the social contexts in which they happened. While Sophie had initially been the center of her husband’s attention who was impatiently waiting for her future children and already showed his serious intentions toward her family, the situation was now almost the reverse: her husband had turned his attention to another wife, and he did not care about Sophie’s childbearing capacities or the wishes of her family members anymore. Etiological notions thus shift along with social contexts. The next section describes



which explanations might be available or relevant at different moments of loss; it further illustrates why it is not surprising that Sophie's interpretations turn from innocent worms to evil witchcraft.

### Perils to Pregnancies: The Local Etiology of Pregnancy Loss

Pregnancy loss (*abum iadigela*, "wasted pregnancy") is a phenomenon that thwarts the patriarchal ideal of bearing many children. Most disruptions therefore raise suspicions and require explanations—determining the treatments to be consulted afterward, as well as the coping reactions of both the woman and her surroundings. In the village study, 76 causes of pregnancy loss have been found, which women themselves often grouped into "larger" classifications (van der Sijpt 2007) and that were confirmed and influenced by local healers. Although not pretending to give an all-encompassing, coherent account of what turned out to be contradicting and varied descriptions of informants—a critique on the representation of ethnomedical "systems" also discussed by Pool (1994)—we will present women's diverse ideas with regard to risks to pregnancy.

First, women indicate that miscarriages and stillbirths are often the result of intense bodily movements during pregnancy. The specific causes they refer to are mostly related to their heavy working conditions and multiple tasks: washing clothes, gathering wood, working in the fields, or carrying heavy weights on their heads. Mama Denise, an older mother of three living children who lost three other fetuses and infants at different stages of gestation, explains the loss of a five-month pregnancy:

I fell with my load when I came back from my field. The fetus is attached to your back, you see? If you carry a basin on your head or expose your back to the sun while you work on the fields, the placenta that normally sticks to your back releases due to the heat and heavy movements. The child cannot stay inside. In the hospital they say that you shouldn't carry heavy things or work too hard when you're pregnant. But here in the village, who will work for you? You're obliged to do everything by yourself. You're simply obliged.

The fact that women primarily stress work-related risk factors to their pregnancies does not come as a surprise; it verbalizes their ambivalent feelings about contradictory duties and loyalties during marriage: having to prove their worth as hard-working daughters-in-law, but at the same time expected to get pregnant and bring this pregnancy to term without any problems. Discourse on work thus provides women an idiom to express complaints and social commentaries, while simultaneously stating commitment and innocence with regard to their own child-bearing intentions—thus doubly confirming their "worth" as a daughter-in-law.

A similar statement can be found underneath the numerous diseases (*mekong*) indicated as possible causes of pregnancy loss. Most biomedically recognized diseases such as AIDS, sexually transmitted diseases (*mekong bunka ne panum*), malaria (*avo*), jaundice (*zom*), or dysentery (*melaab*) are perceived as hot entities in the belly, warming up the blood and, thus, making it impossible for a pregnancy to "stay." Other afflictions—assured to be unrecognized by "the hospital" and in need

of “indigenous treatment”—include the women’s worm (*song bunka*) that Sophie also mentioned with regard to her first pregnancy loss. Diana, a 30-year-old, newly married woman who covered up her secretly induced abortion by claiming to suffer from this women’s worm, explains its workings as follows:

The women’s worm is located in the lower abdomen and has small teeth. As soon as it picks you when you’re over time, it eats the blood that wanted to form a child. Automatically, the blood will flow. And if you have this worm, it hurts a lot! You get it by wearing the clothes of your sister who carries the worm. Or by your husband. If he sleeps with a woman who has the worm, you will also get it. Many women have it here in the village and often it’s not their fault.

Another disease, recognized by many informants to pose a serious threat to successful reproductive outcomes, is called “hot water” (*medii medonga*). Located in the uterus, it might burn the developing fetus in utero or during delivery. Yvette, a 29-year-old woman who lost five of her nine children in a marriage without bride-price, explains the premature loss of her twins as follows:

When I gave birth after eight months of pregnancy, one child died immediately. He got burned by the hot water flowing out of my belly. This is an illness that many women suffer from. It is good when the hot water comes out before the child is born. But if the water follows the child after his delivery, it will burn the baby and his skin will turn black and peel off. That was my case. It happened in combination with the jaundice that I always carry along during pregnancies. Two illnesses in my belly. These killed one of the twins immediately.

“Medical” explanations like these—whether or not they coincide with biomedical etiologies of pregnancy loss—often serve to prove the “innocence” of a specific incidence of loss, which can then simply be cured by hospital or indigenous treatments. The suspicion with which Yvette was faced after many child deaths in a long marriage also surrounded Sophie, who had just started childbearing for a new husband. Because both women faced accusations of in-laws—suspecting witchcraft and abortion practices of Yvette and Sophie respectively—they had a clear interest to externalize and minimize the cause of their misfortunes by exploiting a “neutral” medical discourse. It helped to protect their own fragile positions as “outsiders” in marriage, and to prevent underlying social frictions and suspicions to become explicit.

Apart from being a possible result of reproductive disruptions, social frictions are considered to be a considerable threat to pregnancies as well. Disharmony might lead to the malevolent use of indigenous medicines (*bile*). Especially cowives (*bejomb*), in their struggle for attention of husband and in-laws, might try secretly to attack each other’s reproductive capacities through the use of detrimental herbs, powders, leaves, and bark. Mama Rosie, a dynamic 52-year-old woman who had only borne one son out of wedlock 30 years earlier and never conceived in her current marriage, relates:

When I was 29, I suddenly stopped menstruating. My breasts had already become big and dark; people said that I had conceived a pregnancy. But it wasn't that. I never menstruated ever since. It is my cowife who felt that if I would bear a child here with her husband, she would lose her place as a first wife. The *marabout*<sup>9</sup> told me, "it is your cowife who has blocked . . . she has taken your menstruation blood out of your underwear, mixed it with remedies and attached it somewhere, through witchcraft. You will never bear any children."

Like Mama Rosie, many informants claimed that bile could be more successfully applied if combined with witchcraft (*mgbəl*)—another major cause of pregnancy loss. Witches might attack an innocent pregnant woman in several ways: by applying remedies, entering the belly, stealing or eating the fetus—all during nightly visits. Underlying these diabolic practices is a "bad heart" full of envy and jealousy with regard to the relative wealth, large offspring, or husband's attention a woman possesses. Although within this competitive conjugal context most accusations are prone to develop toward cowives or husband's lovers, they might also be directed toward in-laws or their village members—indicating the distrust between a daughter-in-law and the unknown environment where she settles as a newly married "outsider." A case in point is a marabout's explanation of the two miscarriages of Lisette, Sophie's younger sister, who, like Sophie, had returned to her mother's village after marital problems following her reproductive disruptions:

She said, "Look how they poured mystical remedies into your belly, there where the eggs of the children are. You cannot give birth normally without clearing it, you will always miscarry." And she told me it is a woman in my husband's village who did this to me. Because they see how my husband loves me too much. All the meat he hunts is only for me. And people don't want our well-being. So I first have to treat myself so that I can give birth normally.

At the same time, a miscarrying woman risks being accused of possessing *mgbəl* herself. Witches are said to "offer" their own fetuses during nightly gatherings with other witches or lose their babies during nightly battles with stronger witches. On a more individual level, the power of witchcraft—conceptualized as a little crablike creature (*ivū*) in the belly—satisfies its strong desire for blood by starting to eat or "hold" the fetus, leading to a miscarriage or complicated childbirth respectively. Especially in-laws who eagerly await proof of the goodwill and worth of their daughter-in-law are not hesitant to accuse her of "eating" her—and by implication, their—descendants when she has not been bearing live children for too long a time. Jasmine, a 33-year-old nursery teacher who tried a new marriage after she miscarried and lost a newborn baby in two previous relationships, recounts:

He and his family again deceived me, since I had problems in childbearing. They called me a sterile woman. After one year, they decided that it couldn't last any longer. They organized assemblies to discuss my case and chased

me. They said that it was probably me who killed my children mystically and refused to conceive another pregnancy.

That Jasmine encountered this kind of accusation could not only be related to her repeated reproductive losses—which make any newly married woman suspect of witchcraft—but also to her status as teacher and, thus, earner of regular income, which, like any source of extra wealth in the village, is easily suspected to require certain mystical “offers”—such as fetuses and children.

Another “mystical” danger to pregnancy is malediction (*bidokh*), coming from a woman’s mother or other close relatives. Those who have put much effort in the education of a woman during her youth have the symbolic power to curse their daughter in case of extreme conflict. Exemplary are the many stories of disobedient daughters who get married without their parents’ consent. According to elder village women, only a word or a sentence suffices to call misfortune onto the woman—for instance, “if I was the one who suffered for you, then you won’t bear any live children in this marriage.” Younger women, however, doubt the effectiveness of simple words. They rather attribute negative reproductive repercussions after curses to the influence of witchcraft, as discussed in one focus group discussion:

**Dorine:** Maybe your family doesn’t like your boyfriend and tells you not to love him. But you only insist. They will tell you: well, off you go, but we will see what will happen. You will never bear a live child with him.

**Lisette:** This “we will see” involves however many things!

**Nadine:** Many things even! There is witchcraft involved.

**Charlotte:** There are curses and curses . . .

**Dorine:** There are curses that are uttered with a tongue full of remedies, or those uttered by witches. These curses might affect you.

**Lisette:** People can also simply talk, but their words aren’t realized. But the witch has already heard them speak, and she imposes herself on the situation. She will just take advantage of the possibility to do harm. If the words then realize themselves, people will say: it is because you didn’t want to listen . . .

**Nadine:** Whereas it was a witch who did it to you! When people talk with their mouth without knowing anything [i.e., witchcraft], their words can never be realized.

Cases of malediction demonstrate how a woman’s fertility, although mainly focused onto the family of her partner, can become contested and influenced by her own family members who subject it to social norms and expectations—in this case the requirement that marriages are only concluded in agreement of both lineages. This contestation is itself, however, contested as well; the discussion of the young women illustrates how, even in their own kin group, tensions easily develop into accusations of witchcraft—especially as witches are believed to operate on the most intimate level, preferring to attack their own family members (Geschiere 2003).

These etiological conceptions show how reproductive success is considered as dependent on relational harmony rather than mere individual health and biomedical parameters. Although people identify both naturalistic and personalistic causes of pregnancy loss (Foster and Anderson 1978), there is more attention to personalistic dangers, and even naturalistic accounts—like workload and certain illnesses—reveal certain social stakes when probed further and situated within the social circumstances in which they are expressed. Pregnant bodies are first of all social bodies; fertility is not an individual and isolated affair but, rather, pervaded by social relations and their inherent dynamics. Especially in this patrilineal society in which women's childbearing is wanted by some and lamented by others, a major risk to pregnancy lies exactly in these ambiguous social relations.

Both these social dynamics and the plurality of etiological interpretations allow for a flexible and strategic idiom that can be differently employed by different actors at different moments. Naturalistic and personalistic causes of pregnancy loss imply various degrees of culpability and possibilities of accusation. A miscarrying woman could denominate a possible causation factor that turns the attention either to something negligible ("work" or "the women's worm"), to an abstract agent ("God" or "the witches"), or to specific people with whom social relations were distorted ("my jealous cowife" or "my mother who cursed me")—depending on her social situation and positioning. Indeed, Sophie's shifting interpretations of her two miscarriages—turning from the flow of "only water" through the picking of a worm to the loss of her reproductive capacity threatened by the occult powers of a new cowife—make sense if situated within the drastic transformation of her marital environment and thus her relative power position and social stakes. In both instances, the cause of pregnancy loss was externalized and the self depicted as a sufferer, but with completely different connotations and social implications.

This portrayal of oneself as a passive sufferer might furthermore be an active strategy in a setting where pregnant women are surrounded by ambiguity and suspicion. Indeed, the dualistic distinction between naturalistic and personalistic etiological explanations of loss becomes complicated by the fact that the pregnant woman herself might be a threat to the pregnancy as well—something that everybody is well aware of. Women's strategic employment of etiological notions is needed to divert attention from this possible agentic side of pregnancy loss and to prevent exacerbation of their already precarious position as outsiders in another lineage.

### Exacerbating Ambiguity: The Threat of Induced Abortions

Suspicion of induced abortions in cases of pregnancy loss arises not only from the ambiguous, distrustful relationship between in-laws and their daughters-in-law; it also has a fair and real basis. Although abortion is a criminal offence in Cameroon, punishable under section 337 of the penal code, 11 percent of the 223 pregnancy losses reported by 172 women were indicated to be induced. Many others declared having taken measures to prevent a pregnancy from developing right after sexual intercourse or when detecting a missing period. Numerous methods were cited: from the insertion of sharp objects into the uterus to the application of indigenous

remedies or the intake of biomedical medicines. The concealment surrounding the first trimester of a pregnancy offers women the possibility, space, and time to secretly make an end to their still invisible and unconfirmed condition. Their strategies will go unnoticed or be covered in an idiom of “late period” or “spontaneous miscarriage,” with the above-mentioned etiological notions strategically denoted as would-be causes of the “misfortune.”

There are numerous circumstances and motivations that make an expecting woman decide to end her pregnancy. Often cited reasons include the young age of the girl, fear for parents, the desire to complete education or other aspirations, instability of premarital sexual relationships, misrecognition of paternity by the partner, difficult economic situations, or, for married and older women, extramarital pregnancies, health concerns, or birth spacing—reasons that can be found in other studies as well (Calvès 2002; CEPED 2000; Guttmacher Institute 2003; Henshaw et al. 1999; Koster 2003) and some of which played a role in Sophie’s first abortion attempt.

However, many abortions also paradoxically relate to the particular kinship and marriage situation and its ideology of women having to bear many children for their husband’s patrilineage. This norm, based on an ideal of reciprocal alliances, often becomes contested by women who face conjugal fragility and insecurity in practice. With men (and their families) failing to fulfill the social duty of reciprocity, women might decide to neglect their social duty of fertility. Thus, depending on her evaluations and expectations of her husband’s and in-laws’ behavior, a woman can choose either to adhere to this patrilineal norm to satisfy them, or to actively restrict her—and thus, their—reproduction to “punish” them. This punishment might be motivated by the disappointing behavior of the husband—which triggered Sophie’s second abortion attempt—or by the negligence of a supposedly reciprocal relationship between families, as is the case for Angélique, a 28-year-old woman who aborted her twins out of “anger” against her neglectful and disrespectful husband and in-laws:

I aborted, because I didn’t want to bear a child anymore. I was very angry with my husband and his parents. My family hasn’t eaten anything! So I told myself: if I give yet another pregnancy, I will suffer a lot. And we were already with two women in the house. My cowife had already entered. Life was not good when I was all alone; how bad will it become when my husband has already two wives to take care of? No, I preferred to abort. My mother supported my decision. Now I tell myself and my family, “I will not bear a child anymore before he pays his debt to my parents and treats me better as well.”

This possible intentional aspect of pregnancy loss is constantly present but always hidden within the insecure conjugal context where fertility is so at stake but norms and realities are so disparate. According to the social circumstances, pregnancies can thus be wanted or unwanted; consequently, they might be carefully protected from or consciously exposed to risks—while always leaving outsiders in the uncertainty of suspicion.

## Dynamics Discussed

The foregoing discussion of dynamics around pregnancies and loss in the East province of Cameroon has shown that several points of attention in the international reproductive health arena have become blurred or irrelevant when situated within local social contexts. In contrast to the explicit medical focus on risks of pregnancies to women in third-world countries, local perceptions in Cameroon centralize risks to pregnancies, often coming from relevant social others (cf. Allen 2002). Pregnant bodies are social bodies, which are socially vulnerable because situated within and pervaded by uncertain kinship and marriage dynamics. Thus, in the etiology of pregnancy loss in East Cameroon, in-laws, family members, and pregnant women themselves can be a considerable threat to pregnancies. International policies on management and treatment procedures with regard to reproductive loss rarely take into account these encompassing notions of fertility risks.

These notions and experiences are further shown to vary immensely—with losses not only being interpreted differently by women of different ages, of different families, and with different marital statuses, but also shifting their meanings over a lifetime, changing along with the social circumstances in which they happen. Static stories of “hypothetical women” that pervade international reproductive health debates are therefore likely to distort these real-life variations between both social positions and social situations.

This distortion pertains all the more because of the strict divide between spontaneous and induced loss such hypothetical cases maintain—a distinction that is shown to be blurred in this social setting. Spontaneous losses are often suspected to be provoked; induced abortions are often presented as spontaneous ones. Especially for outsiders, who are aware of the “outsider” status of (newly) married women and its concomitant ambiguities, the intentionality of loss remains rather indeterminate. This indeterminacy in turn becomes exacerbated by the existing plurality of etiological notions able to cover women’s ambiguous ambitions. Local notions of loss are thus not only more encompassing and diverse than assumed in global debates, but they also acquire strategic values that cannot be understood if not situated within local atmospheres of ambivalence.

Thus, this article has made clear that, without paying attention to the social body of pregnant women, a focus on the body politic or “hypothetical” individual bodies remains partial and distorted. To really understand women’s reproductive aims and experiences, we should consider their socially situated sorrows and strategies.

## Notes

*Acknowledgments.* The authors want to thank the participants of the panel “Infertility: Links” at the Reproductive Health Challenges Conference in Granavolden (Norway), where the paper on which this article is based was presented and discussed, as well as anonymous referees, for their valuable comments and suggestions for improvement.

1. For social scientific literature on high fertility levels in Cameroon, see for example Calvès and Meekers 1997, Nana-Fabu 2001, and Wakam 1992. Studies on experiences of infertility in Africa include, among others, Becker 1994, Boerma and Mgalla 2001, Inhorn 1994, 1996, and Leonard 2002.

2. Definitions and classifications of pregnancy loss are multiple, overlapping, and sometimes contradicting. On the basis of the question of intentionality, a distinction is often made between induced and spontaneous pregnancy loss—the latter being subdivided into miscarriages and stillbirths according to the gestational stage of the failing pregnancy. A miscarriage entails the loss of a pregnancy when the conceptus is believed to be unviable; the loss of a fetus that would have been able to live outside the womb but dies in utero or immediately following delivery is called a stillbirth. However, as viability is legally defined and changes by national context, there is no universal agreement on the precise dividing line between miscarriages and stillbirths and, thus, their respective definitions. In this article, we will transcend existing definitions and classifications: our use of the words *pregnancy loss* will denote all cases where a pregnancy does not result in a live birth—regardless of the woman’s intentionality or the pregnancy’s gestational stage.

3. Although the divergences in estimated failure rates of pregnancies may result from different measuring methods and the fact that many losses occur imperceptibly—without the woman knowing that she was in fact pregnant—it should also be stressed that pregnancy loss concerns a biological event that is liable to local variations and frequencies. In this sense, Margaret Lock’s (1993) notion of “local biologies” is more telling than general estimations that either overlook or try to incorporate all these local rates of recurrence.

4. Especially Cecil’s edited volume *The Anthropology of Pregnancy Loss* (1996) provided a good starting point that called for more comparative research on reproductive mishaps. A number of ethnographers answered Cecil’s call by investigating the cultural constructions, meanings, and politics around pregnancy loss in various parts of the world (e.g., the work of Erviti et al. 2004 in Mexico, Jeffery and Jeffery 1996 in India, Layne 2003 in the United States, Littlewood 1999 in the United Kingdom, or Njikam Savage 1996 in Cameroon).

5. Although people speak the local Gbigbil language, most of the villagers were able to express themselves fluently in French as well. The citations presented in this article have been translated from French into English as accurately as possible.

6. For more research on social relationships and relational selves in African cultures, among others, see Csordas and Lewton 1998, Devisch 2003, Feldman-Savelsberg 1999, Piot 1999a, and Wakam 1992.

7. This is especially the case when the father of the pregnancy does not recognize paternity or neglects his financial responsibilities during and after pregnancy, after which the child will grow up in the woman’s family. If this man then comes to claim his child after six years, the maternal family might demand compensation for their efforts and care for mother and child—or refuse to let ‘their’ descendants go altogether.

8. Mectizan<sup>®</sup> is widely used by onchocerciasis, and lymphatic filariasis control programs and is freely distributed once a year among Cameroon’s population.

9. An encompassing definition of marabouts could be: traditional, often Islamic, healer from the North of Cameroon, healing on the basis of clairvoyance, incantations, mystical powders, and natural products.

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