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van der Sijpt, E.

**DOI**

[10.1080/13648470.2013.842415](https://doi.org/10.1080/13648470.2013.842415)

**Publication date**

2013

**Document Version**

Final published version

**Published in**

Anthropology & Medicine

[Link to publication](#)

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

van der Sijpt, E. (2013). Hiding or hospitalising? On dilemmas of pregnancy management in East Cameroon. *Anthropology & Medicine*, 20(3), 288-298.  
<https://doi.org/10.1080/13648470.2013.842415>

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Publisher: Routledge

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## Anthropology & Medicine

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/canm20>

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Published online: 07 Oct 2013.

To cite this article: Erica van der Sijpt , Anthropology & Medicine (2013): Hiding or hospitalising? On dilemmas of pregnancy management in East Cameroon, Anthropology & Medicine, DOI: 10.1080/13648470.2013.842415

To link to this article: <http://dx.doi.org/10.1080/13648470.2013.842415>

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## Hiding or hospitalising? On dilemmas of pregnancy management in East Cameroon

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*(Received 15 September 2012; final version received 5 September 2013)*

Current international debates and policies on safe motherhood mainly propose biomedical interventions to reduce the risks during pregnancy and delivery. Yet, the conceptualisations of risk that underlie this framework may not correspond with local perceptions of reproductive dangers; consequently, hospital services may remain underutilised. Inspired by a growing body of anthropological literature exploring local fertility-related fears, and drawing on 15 months of fieldwork, this paper describes ideas about risky reproduction and practices of pregnancy protection in a Cameroonian village. It shows that social and supernatural threats to fertility are deemed more significant than the physical threats of fertility stressed at the (inter)national level. To protect their pregnancies from those social and supernatural influences, however, women take very physical measures. It is in this respect that biomedical interventions, physical in their very nature, do connect to local methods of pregnancy management. Furthermore, some pregnant women purposefully deploy hospital care in an attempt to reduce relational uncertainties. Explicit attention to the intersections of the social and the physical, and of the supernatural and the biomedical, furthers anthropological knowledge on fertility management and offers a starting point for more culturally sensitive safe motherhood interventions.

**Keywords:** safe motherhood; risk perceptions; pregnancy care; Cameroon

### Introduction

In the contemporary era of international attention to reproductive health issues all over the world, pregnancies have become an object of increasing surveillance. Global programmes such as the Safe Motherhood Initiative or the Millennium Development Goals have portrayed pregnancies as potentially dangerous, risky, and at times unwanted affairs that should be prevented or medically controlled if need arises. Especially in settings where biomedical care during gestation and childbirth is lacking or inaccessible (in geographical, financial, or cultural terms), complications that develop during pregnancy or delivery might pose considerable risks of maternal morbidity and mortality. Key strategies for the reduction of these risks include the monitoring of pregnant women (particularly those identified as being 'at risk' of certain pathological conditions), ensuring their access to biomedical institutions both before and during birth, and providing family planning services afterwards (Bullough et al. 2005; De Brouwere and van Lerberghe 2001). These strategies have become integral components of a global attempt to attain reproductive health for all – an attempt that, thus far, has yielded rather disappointing results.

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Although such efforts to improve women's health are laudable, the conceptualisations of risk that underlie them can be criticised in several ways. First of all, they are highly individualised. Risky fertility events are considered to have repercussions on individual female bodies only – or, at most, on the foetuses they carry. Second, the risk discourse is decontextualised. Pregnancy-related risks are portrayed as universal givens, affecting female bodies all over the world, irrespective of the local contexts in which such risks may arise and assume meaning. Third, the discourse is highly medicalised. The explicit attention to physical problems and their management procedures reflects how the international health establishment rests heavily on biomedical pillars. Even attempts to account for social determinants of maternal morbidity and mortality, such as the 'three delays model', take a biomedical view of what reproductive risks are (i.e. physical complications) and how they should be addressed (i.e. biomedically) as a starting point. Overall, what prevails is a rather technical story pervaded by particular Western assessments of risk.

Yet social scientists have shown that risks are cultural constructs that make sense within the specific contexts in which they are defined and managed (Boholm 2003; Caplan 2000; Cohen 2000; Douglas 1983). Consequently, local notions of risk may diverge from those prevailing on an international level. Since the 1990s, medical anthropologists have explored the perceptions of dangers surrounding reproduction in particular socio-cultural settings (Allen 2002; Bledsoe 2002; Chapman 2003, 2010; Einarsdóttir 2000; Feldman-Savelsberg 1999; Scheper-Hughes 1992). Allen (2002) and Chapman (2003, 2010), for instance, have wonderfully shown how, for women in Tanzania and Mozambique respectively, social threats to pregnancy matter more than the physical risks of reproduction that are the focus of global safe motherhood initiatives. As a result, antenatal hospital services remain largely underutilised; women prefer to resort to healers and medicines that address these social dangers instead.

In exploring local risk perceptions and protective practices around pregnancies in Cameroon, this paper builds upon, and contributes to, this growing body of literature. Yet, contrary to the focus of most of these studies, this paper will be explicitly attentive to the intersections of the social and the physical, and of the supernatural and the biomedical. In doing so, it will show how, in eastern Cameroon, hospital services can be attractive options to pregnant women.

## Methodology

The presented insights are based on 15 months of anthropological fieldwork between 2004 and 2009 in East Cameroon. The research explored notions and experiences of pregnancy loss in a village inhabited by approximately 1000 Gbigbil people. This village is slightly larger than the surrounding hamlets in this sparsely populated rainforest area; it has a kindergarten, a primary school, a secondary school, several churches of different Christian congregations, and a health centre with a maternity ward. Attracting people from neighbouring settlements, its public life is animated and characterised by diversity and mobility.

Most of the data were gathered through participant observation while women worked in their fields and households, visited markets, churches, hospitals and healers, or experienced reproductive events such as deliveries and abortions. Observations were also conducted in the local health centre, a Catholic health centre in a neighbouring village, and two larger hospitals in surrounding towns. Further, interviews and focus group discussions were held in French with 25 women having different ages, educational histories,

economic backgrounds, marital statuses, and reproductive experiences. These women's partners and family members, as well as the village's healers and biomedical staff, were also involved in the study. To unravel pregnancy-related risk perceptions, free listing and pile sorting techniques were used. In a subsequent group discussion, informants were asked to rank the identified risks according to their severity. Lastly, a household survey mapped the marital and reproductive histories of 290 women in the village, aged 12 or more, who had started their sexual lives.

All interviews and focus group discussions were recorded and transcribed verbatim. Both during data collection and in the analysis and writing phases, ethical issues were dealt with as proposed by research ethics committees.

### **Pregnancies and their perils**

In this East Cameroonian village, reproduction is an omnipresent but ambiguous affair. It is ambiguous because norms and practices are increasingly at odds with each other. Ideally, childbearing should be part of a larger matrimonial exchange in which a woman moves to her husband's compound and bears children for his patrilineage once her family has received the first set of a long string of bride-price payments. In practice, however, people often engage in multiple and unstable relationships in which bride-price transactions are postponed or completely absent.<sup>1</sup> Within these insecure liaisons, bearing children is not always the primary aim of either partner, nor does it necessarily lead to the consolidation of a union. Getting pregnant can be an important strategy for women to convince their partners of their worth and of the necessity to initiate familial negotiations, since men generally want to see a proof of fertility before they even consider the option of engaging more formally. Yet, at the same time, youngsters indicate that partners may disappear upon the discovery of a pregnancy, while married women complain that they constantly bear children while their families 'don't get to eat anything' – thus denouncing the absence of a reciprocal relationship between alliances. Conceiving a pregnancy, then, implies a risk: as much as it could strengthen a relationship, it may lead to abandonment or 'neglect' within a conjugal arrangement of which women (and their family) have other expectations.

Not only is reproduction a risk, but it is also at risk. In this uncertain marriage market, women compete for the attention and (often restricted) resources of men, the most promising of which are called 'big fish'. Fertility is an essential component in this quest. Women may use their pregnancies to try to bind a certain 'big fish' to them, even if he is in fact not the biological father, and even if his commitment will only be temporary. They may even try their luck with more than one 'big fish' at a time – i.e. appoint different promising partners as the 'father' of the unborn child in the hope that one of them will assume responsibility (Van der Sijpt 2011). As different pregnant women can claim commitment from one and the same man, pregnancies easily become an object of jealousy and occult intervention by co-wives or other female competitors interested in that partner.

Further, reproduction is at risk when it becomes an object of familial contestation. Disgruntled by the absence of reciprocal ties, family members are often eager to claim the children of their daughter as long as they have not received any bride-price payments. Conflicts between alliances over the belonging of the unborn child can put a pregnancy at risk, as any of the claimants could decide to destroy the contested descendant. Indeed, in the complicated social situations in which pregnancies are currently conceived and contested, not only co-wives and other female competitors, but also in-laws and relatives may have an interest in damaging a pregnancy. Through witchcraft, that is.

These social and supernatural threats take centre stage in people's ideas about the provenance of so-called 'wasted pregnancies' (i.e. pregnancies that do not result in a live birth) and maternal deaths. 'Wasted pregnancies' are common in this Gbigbil village: of the 240 surveyed women who had ever been pregnant, 60% reported experiencing at least one mishap. Maternal mortality rates were more difficult to trace, but the national estimate of 669 deaths per 100,000 births (Barrère 2005) and the numerous stories about deceased pregnant women that came up during fieldwork point to the magnitude of the problem. Asked about possible perils during pregnancies and deliveries, Gbigbil women identified numerous risks, which they grouped into 'larger' categories: heavy movements; diseases (both biomedically recognised and folk illnesses); disrespect for, or ignorance of, behavioural prescriptions; indigenous medicines (applied by malevolent others or by oneself); witchcraft; and malediction (Van der Sijpt and Notermans 2010). Yet, of all possible risks, people unanimously agreed that witchcraft represents the greatest and most common threat. In a severity ranking exercise, several women commented:

*Dorine:* Witchcraft is the worst. Because it's difficult, witchcraft.

*Lisette:* Because you can at least avoid the other risks, but witchcraft, you can't. . .

*Nadine:* If you're not a witch yourself, how will you avoid it?<sup>2</sup>

*Dorine:* Of course, if you're not a witch, you will try to avoid it. But the witch will always come. What can you do about it? Whereas heavy movements, for instance, you can avoid.

Pregnancies are thus considered more vulnerable to social threats than to physical problems. And since those social threats are perceived to be omnipresent in the contested and competitive domain of reproduction, a careful management of one's pregnancy is indispensable.

### **Pregnancies in practice**

To manage a pregnancy carefully means to hide it as much as possible. Although Gbigbil women generally claim to recognise a pregnancy even before they miss their period – based on physical indicators such as a quicker heartbeat, increased weight and temperature, fatigue, headache, nausea, cravings, lighter complexion, or darker nipples – they will do everything to conceal their pregnant state, and to dismiss the symbolic warnings of watchful *mamas* telling them that they 'have eaten bananas', 'collected something', or 'carry a baggage'. This initial silence and denial are inspired by embryological notions and by considerations of the risks discussed above. Since early pregnancies are believed to contain 'only blood', they are attractive targets for witches, who are generally known to 'suck people's blood'. Given the omnipresence of such witches, even the closest family members and in-laws should remain ignorant of the pregnancy for as long as possible (cf. Beninguissé 2003; Chapman 2003).<sup>3</sup>

Even when the belly starts protruding and denial becomes untenable, caution is deemed necessary, because malevolent others may smell 'the odours of pregnancy' or recognise the growing belly. Pregnant women generally try to hide their belly under a wide dress and carry protective chains around the waist. Furthermore, mothers-to-be will be subjected to numerous prohibitions regarding moral behaviour, daily activities, physical appearance, and food intake – all of which should be respected to ensure a successful

gestation and delivery.<sup>4</sup> After six or seven months of gestation, a pregnant woman who stays in the compound of her husband leaves it to ‘wait for the delivery’ with her relatives. Here, she expects to get more privacy, rest, care, and knowledge of indigenous medicines for a quick and safe delivery. These ‘remedies of the vagina’ are inserted or evaporated into the vagina, carried in underwear or in cords around the waist, introduced into the rectum, or rubbed in incisions in the lower back or abdomen, in order to enlarge the pelvic opening during childbirth.

The intimate sociality of childbirth preparation contrasts sharply with the isolation during labour itself. Even if most women give birth in the company of a mother, sister, or another relative with birthing experience, a delivery should go unnoticed to most outsiders and happen quickly. Observations during home deliveries revealed the use of different remedies to accelerate foetal descent: a mixture of garlic, onion, and ginger is believed to ‘sting’ the child; rectally inserted rasped coco yam is thought to ‘scratch’ the child; an enema of pepper and soap would ‘heat’ the child; eating honey should ‘energise’ the child; and a constant gentle tapping on the belly is supposed to ‘awaken’ the child.

This preoccupation with quick labour is inspired by several fears. First, women worry about the physical damage caused by deliveries that last too long. Prolonged labour diminishes one’s volume of blood and amount of ‘force’ (as blood is perceived to be the repository of vital energy) more than normal deliveries. Although abdominal massages, herbal remedies, and special (blood-resembling) food preparations can restore blood and ‘force’ levels after these moments of depletion, too much blood loss during a delivery may just prove fatal. Second, prolonged labour is feared to attract social attention. The longer labour lasts, the more people may become aware of it – including witches or people with a ‘bad heart’ eager to ‘block’ the delivery through symbolic or occult actions. At the same time, obstructed labour in itself raises the suspicion that such interventions are already ongoing. Difficult deliveries are often feared to be the effect of complications in the social rather than the physical realm. Several indigenous remedies can be inserted in the vagina or rubbed over the belly to ‘undo’ such blockages caused by others.

Among the various measures to protect pregnancies and deliveries from social threats, many are physical in nature: women carefully observe the bodily symptoms of their pregnancies, apply ‘remedies of the vagina’ for a quick delivery, and use post-partum remedies to strengthen their bodies (which may again become the object of malevolent intervention during subsequent pregnancies). The following section explores if, how, and why biomedical services connect to these local modes of pregnancy management.

### **Hiding or hospitalising?**

Cameroonian health policies stipulate that all health centres in the country, even the smallest ones, should offer basic but comprehensive maternal care (i.e. antenatal care, basic emergency obstetric care, and family planning services). These policies have been heavily influenced by the global discourse on pregnancy risks as outlined in the introduction; ever since Cameroon’s admission to the Highly Indebted Poor Countries Initiative in 2000, international interventions and targets – such as the Millennium Development Goal of reducing maternal morbidity and mortality – have become important determinants of national health strategies. The maternal care offered in private and faith-based (reproductive) health centres in the country is no less influenced by these international priorities.

The public dispensary in the research site offers antenatal services including measurements and diagnostics of pregnancy parameters (blood, urine, temperature), and is

endowed with a delivery room, delivery table, and some rudimentary medicines for basic obstetric care and post-partum services. Monthly antenatal consultations add up to 1500 CFA Francs (around €2.25); deliveries cost 5000 CFA Francs (around €7.5).<sup>5</sup> A Catholic health centre situated 3 km from the village offers antenatal services at similar prices but does not facilitate deliveries. The bigger hospitals in cities at 15 and 65 km distance provide more advanced, yet more expensive, services – the furthest one also offering ultrasound and caesarean sections.

In the local logics of pregnancy care, a hospital visit may be risk-inducing rather than risk-reducing. Going to a medical establishment in a wide *kabba* dress (required for pregnant patients) equals publicising one's pregnancy; it is easily remarked by outsiders and exposes pregnant women to the bad eyes of witches. This is an important reason for women to stay home. Other reasons for not using reproductive health care include embarrassment in front of the male doctor, lack of French fluency, lack of money, or simply the absence of any complications during pregnancy or delivery (c.f. Beninguissé 2003; Chapman 2003; Olivier de Sardan, Moumouni, and Souley 2000). Mothers in particular seem powerful actors in deciding against biomedical care. This was the topic of discussion, for instance, when a woman who had lost her baby in a dramatic home delivery visited the health centre for post-partum care:

*Woman* [screaming]: Isn't it all right now, doctor? Oh, God! It hurts!

*Doctor*: Is it your mother who made you deliver? It is pity that makes me take care of you now! But I tell you: the village is dangerous. The other day, they almost assassinated a pregnant girl there. The girl wanted to come to the health centre. The old *mamas* told her not to go.

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

*Doctor*: Even her husband wanted to come here.

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

*Doctor*: Yes, up to the level that the *mamas* did an episiotomy with their nails! That's organised assassination!

This interaction reveals not only the intergenerational power relations at play during moments of decision-making, but also the doctor's disagreement with (the outcomes of) this power play. As much as village *mamas* oppose risky hospital visits, doctors denounce the risky malpractice and misconceptions of *mamas*. Faced with different rationales of risk, then, many women in the village contrast the advices of their mothers with biomedical recommendations. In an educational session for pregnant women at the health centre, some participants articulated these discrepancies as follows:

*In the village, they tell us that we shouldn't eat eggs, since the child will be born with dirt in his eyes. What to do?* [Reaction to the recommendation of a protein rich diet]

*I will soon deliver my first child. The village *mamas* tell me that I shouldn't cut my nails, because the child would not be able to tear his placenta during labour. Is that correct?* [Reaction to nail clipping prescription]



*Some people say it is not even allowed to 'play', to 'taste the ball', towards the end of the pregnancy. Is that true? [Reaction to the metaphorical advice of 'playing football', i.e. having sexual intercourse, only intermittently]*

The contradictions of pregnancy-related recommendations can make women sceptical towards biomedical staff and towards their own (grand)mothers. Yet, at the same time, this multiplicity of prescriptions allows them to strategically deploy one interpretation or the other; depending on the situation, women can invoke 'knowledge of the ancestors' or 'knowledge of the whites' as justifications for their own practices. Although these two regimes of risk reduction appear to be in contrast with each other, together they offer an amalgam of options and opinions that women may exploit in rather complementary ways.

Indeed, in some situations and for some reasons, women of all sorts do opt for biomedical care during pregnancy – even if they rarely start prenatal visits during the recommended first trimester, and seek delivery care only when the darkness of the night has closed the eyes of others. Yearly, about 100 pregnant women out of a population of 6832 inhabitants (dispersed over seven villages)<sup>6</sup> attend antenatal care in the village's health centre, and a handful come to give birth here as well. Others visit medical establishments in the surroundings – a situational choice that depends on the availability of personnel and medicines, personal connections, previous experiences, the financial capabilities of partner or family members, the available means of transportation, and other contingencies. Overall, it is not uncommon to hear women say that they delivered some of their children at home and others in one (or more) of the health centres in the region; or that, before (some of) their home births, they sought antenatal care in one (or more) medical establishments. What is it, then, that makes biomedical reproductive health care attractive?

### *A continuum of care*

First, the physicality of biomedical examinations parallels women's material pregnancy management. Despite their social and supernatural vulnerabilities, pregnancies are largely experienced and managed physically: bellies are carefully watched, touched, and tapped, while remedies are 'vaccinated' into the skin, introduced into the rectum, inserted or evaporated into the vagina. This materiality also pervades biomedical antenatal care; doctors' measurements and palpations of the belly, injections of substances into the veins, prescriptions of pills to be swallowed or vaginally inserted, and examinations of blood and urine add to a Gbigbil repertoire of pregnancy interventions and evaluations. This physical biomedical care is also deemed effective after deliveries. Many women claim that post-partum hospital services, especially injections, keep them energetic, strong, and well prepared for their next pregnancy (when social and supernatural problems may be encountered again). One informant explained that 'indigenous remedies are strong but only indirect. Compare them to vitamin pills: you can take them, but you will only gain weight some time afterwards. They don't give you blood like hospital injections that enter the veins directly'. Ideally, then, post-partum massages and concoctions are combined with hospital visits.<sup>7</sup> 'Indigenous' and biomedical interventions form a continuum of concrete care; they are complementary rather than competitive forms of physical pregnancy management.

Second, biomedical antenatal care offers visual facilities that may reduce women's reproductive uncertainties. While informants would generally answer questions about embryology with claims that 'one cannot see what is in the belly', proponents of antenatal care would posit that medical doctors 'can see the conditions of the belly'. In this setting

where only witches are believed to be able to ‘see’ inside the uterus, ultrasound (in urban hospitals) is credited with great powers. In this respect, doctors are sometimes compared to ‘good witches’ or ‘*marabouts*’ (local healers of Muslim denomination who can ‘see’ and fight witchcraft). In a discussion on ultrasound, an older *mama* said: ‘the doctor is like a *marabout*. If he tells you something, you do not know exactly *why* he says it, but he has knowledge that we don’t have. That’s what matters’. Just like pregnant women may consult local healers, they might want to hear a doctor’s opinion about the conditions of their pregnancy.

A third attraction of biomedical supervision of pregnancies lies in its labour management. As most people fear the social and physical implications of prolonged deliveries, biomedical labour inducing measures (such as oxytocin) are considered valuable interventions: accelerating the birthing process, they can make the delivery both socially and physically safer. The injectable form of this intervention reinforces its perceived effectiveness, as medicines that ‘enter the blood directly’ are deemed more powerful than anything else. Most women who enter the hospital with a request for such an intervention do so after prolonged labour at home – thus situating the biomedical intervention within a wider local repertoire of accelerating remedies. In several ways, then, biomedical services can be pragmatically incorporated in women’s attempts to protect their pregnancies from social and supernatural threats.

### ***Relational risk reduction***

Pregnancies are not only *at* risk but may also constitute *a* risk in the uncertain relationships in which they are conceived. In the social negotiations after conception, the question of whether or not to use biomedical services can take centre stage. In the current absence of bride-price payments (which used to establish a husband’s paternal rights over the children his wife would bear), some unwritten rules have developed that ensure a man’s *de facto* right over his descendants as long as he acknowledges paternity and provides financially for mother and child. Paying for pregnancy-related care is an integral part of this process; it shows a man’s commitment to fatherhood and serious intentions regarding the relationship. Faced with a pregnancy in an unstable liaison, women (and their families) ‘test’ their partners accordingly: they purposefully propose antenatal or post-partum visits in order to see whether their partners are willing to finance them – and thus acknowledge commitment. Angélique recalls the familial negotiations around her first pregnancy, which initiated her ‘marriage’ (in which the bride-price would never be paid):

I lived with my uncle and his wife knew that I was pregnant. She therefore called my boyfriend, to come and present himself. Because I had to start antenatal consultations, she said. He came together with his mother. They talked for a loooong time. They accepted. The next day, they gave me the money and I went for antenatal visits.

Once a man accepts to pay for pregnancy-related care, some women decide to take the most out of it – knowing that his commitment could be only temporary. Charlotte, who conceived with an urban ‘big fish’ and obtained his financial support for prenatal check-ups in an urban maternity, reported a much higher price for the prescribed medicines than what she had actually paid, and untruthfully told her boyfriend that the doctor had recommended an ultrasound scan – something that would cost 10,000 CFA Francs (around €15). While most men deem an ultrasound scan necessary only in case of serious reproductive problems, women often assert or invent a medical need in order to claim, test, or

use the responsibility of their promising partners. Charlotte succeeded; satisfied with the 5,000 CFA Francs (around €7.50) she obtained, she laughingly whispered that she had to make sure he would not ask for proof in her maternity booklet, as her dishonesty could make her boyfriend disengage after all.

Similar strategies can be employed even if there are no intentions to stabilise a relationship. Proposing a hospital visit is then purely an attempt to obtain money from a lover. Having conceived with somebody who already had two wives and who showed little commitment, Marie invented different medical problems in order to receive some money from the man she knew she would never (want to) marry:

I even told him that I had taken some pills to abort the pregnancy and that the blood was already flowing. That I wanted money for an ultrasound in the city to see the condition of the child. He said I should first go for a normal antenatal visit. He gave me 10,000 Francs [around €15]. But I knew that I wasn't sick at all! So I went and told the doctor that I had back pains and vaginal discharge. He prescribed some medicines.

Financial contributions for prenatal consultations may thus be requested even if women do not want to attend antenatal care at all, and aim to spend the money on different things. Such strategies may be very well known by, or openly shared with, doctors. The pregnant Louise, who had never set foot in the village's health centre even though she lived next door, once asked the doctor, 'Can't you prescribe everything that you would like to prescribe in my maternity booklet? Everything! Even if I don't take it. I will tell my boyfriend "This is what the doctor has prescribed". He will give me that money'. The doctor, in turn, grumbled that too many women these days just come for prescriptions and never return to buy the actual medicines.

Biomedical services, then, can be proposed and pursued in different ways and for different reasons, depending on the relational aspirations of both men and women. Whether or not women believe such care actually reduces reproductive risks, it certainly represents a starting point for alleviating the relational and financial uncertainties that surround pregnancies in East Cameroon.

## Conclusions

This paper has shown that reproduction is a dangerous domain for Gbigbil people in Cameroon. Within the current marriage and kinship dynamics, fertility is both *a risk* and *at risk*. Pregnancies can consolidate uncertain unions, but may at the same time be contested by family members demanding a bride-price, by neglectful partners and in-laws, or by jealous co-wives and female competitors. This precariousness is reflected in pregnancy-related risk perceptions and protective practices. Although Gbigbil people identify multiple physical risks during pregnancy or delivery, the most dreaded threats are those posed by witches and malevolent persons. Contrary to the explicit focus on the risks of (pathological) pregnancies in global reproductive health debates, Gbigbil women stress risks *to* pregnancies, mostly coming from relevant social others. Pregnancies are therefore carefully hidden and protected.

Yet, among the measures women take to protect their pregnant bodies from social and supernatural dangers, many are physical in nature. And it is here that biomedical services connect to local experiences and expectations of pregnancy care. The bodily examinations during antenatal check-ups, the labour-inducing interventions, and post-partum treatments that enhance physical strength are sometimes considered attractive

complements to local methods of pregnancy management. Furthermore, Gbigbil women purposively propose and pursue hospital visits in their negotiations with indecisive partners. By claiming a need for (money for) biomedical surveillance, they attempt to reduce the relational and financial risks that surround their pregnancies.

Situating reproductive dangers and desires in their local context has unveiled the intersections between the physical and the social, and between the biomedical and the supernatural, in women's reproductive lives. These insights can be useful both for anthropological studies in different localities and for safe motherhood interventions designed at the international level. For, in their attempts to show the cultural underpinnings of reproductive risk perceptions, anthropologists have mostly attended to the social and supernatural dangers to fertility. While such insights are very valuable, an explicit focus on the physicality of pregnancy management, as well as on the material needs and insecurities around pregnancies, sheds new light on people's reproductive practices and priorities, as well as on the role of biomedical services therein.

Such insights also offer a possible starting point for more culturally-sensitive safe motherhood interventions; they give a locally grounded alternative to the technical views of risk that currently inform policy-making, without discarding the merit of biomedical services altogether. They show that, even if local perceptions – foregrounding social and supernatural fertility threats – do not chime with the international reproductive risk framework, practices of protection can converge. Although appreciated for different reasons, physical antenatal examinations, quick deliveries, and post-partum treatment can become the shared projects of women and doctors. Applying a broader concept of reproductive risk than the one currently in vogue can illuminate these alternative motivations for attending pregnancy-related care and help explore possible connections between biomedical interventions and local methods of pregnancy management. This, in turn, may bring us one step closer to attaining the reproductive health goals that, to date, are not achieved in a satisfactory manner.

### Acknowledgements

The author would like to thank the Amsterdam Institute for Social Science Research (AISSR) for facilitating the study that yielded the insights presented in this paper. Ethical approval was granted by the AISSR when the research project was accepted. Conflict of interest: none.

### Notes

1. Informants and several studies (Abega 2007; Johnson-Hanks 2006; Meekers and Calvès 1997) attribute the current neglect of marital obligations to the economic crisis plaguing Cameroon since the late 1980s.
2. Nadine alludes to the fact that witches operate in a world that can only be seen by those who are endowed with occult forces, and not by 'normal' people.
3. Women may, however, inform their partners about an early pregnancy, since men's reactions are often crucial in deciding whether to keep a pregnancy, 'give' it to someone else, or abort it altogether.
4. The 51 prohibitions found in this study were mostly based on the principle of analogy. For instance, standing still on a threshold would prolong labour; wearing necklaces would wrap the umbilical cord around the child's neck; eating eggs would develop a hairless baby; and quarrelling would make the child refuse to descend at birth.
5. For the sake of comparison: a loaf of bread cost 100 CFA at the time of this study.
6. The 2009 census revealing this population number also noted that 4939 people lived within 5 km from the health centre, while 1879 others lived further away. The pregnant population was estimated at 342 women (5% of the total population).

7. This is even more so after a ‘wasted pregnancy’ – feared to cause more blood loss than child-birth. Of 173 women who had experienced such an event, 49.7% indicated having sought biomedical services afterwards.

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### References

- Abega, Séverin C. 2007. *Les Violences Sexuelles et l'État au Cameroun*. Paris: Karthala.
- Allen, Denise R. 2002. *Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania*. Ann Arbor: University of Michigan Press.
- Barrère, Bernard. 2005. “Mortalité adulte et mortalité maternelle.” In *Enquete Démographique et de Santé 2004*, 225–233. Calverton: ORC Macro.
- Beninguissé, Gervais. 2003. *Entre Tradition et Modernité: Fondements Sociaux de la Prise en Charge de la Grossesse et de l'Accouchement au Cameroun*. Louvain-la-Neuve: Bruylant-Academia.
- Bledsoe, Caroline H. 2002. *Contingent Lives: Fertility, Time, and Aging in West Africa*. Chicago: University of Chicago Press.
- Boholm, Åsa. 2003. “The cultural nature of risk: Can there be an anthropology of uncertainty?” *Ethnos* 68(2): 159–178.
- Brouwere, de Vincent, and Wim van Lerberghe. 2001. *Safe Motherhood Strategies: A Review of the Evidence*. Antwerp: ITG Press.
- Bullough, Colin, Nicolas Meda, Krystyna Makowiecka, Carine Ronsmans, Endang L. Achadi, and Julia Hussein. 2005. “Review: Current strategies for the reduction of maternal mortality.” *BJOG* 112(9): 1180–1188.
- Caplan, Pat, ed. 2000. *Risk Revisited*. London: Pluto press.
- Chapman, Rachel R. 2003. “Endangering safe motherhood in Mozambique: Prenatal care as pregnancy risk.” *Social Science & Medicine* 57(2): 355–374.
- Chapman, Rachel R. 2010. *Family Secrets: Risking Reproduction in Central Mozambique*. Nashville: Vanderbilt University Press.
- Cohen, Maurie J. 2000. *Risk in the Modern Age: Social Theory, Science and Environmental Decision-Making*. New York: Palgrave.
- Douglas, Mary. 1983. *Risk and Culture: An Essay on the Selection of Technical and Environmental Dangers*. Berkeley: University of California Press.
- Einarsdóttir, Jónína. 2000. “Tired of Weeping”: *Child Death and Mourning among Papel Mothers in Guinea-Bissau*. Stockholm: Almqvist & Wiksell.
- Feldman-Savelsberg, Pamela. 1999. *Plundered Kitchens, Empty Wombs: Threatened Reproduction and Identity in the Cameroon Grassfields*. Ann Arbor: University of Michigan Press.
- Johnson-Hanks, Jennifer. 2006. *Uncertain Honor: Modern Motherhood in an African crisis*. Chicago: The University of Chicago Press.
- Meekers, Dominique and Anne E. Calvès. 1997. “‘Main’ girlfriends, girlfriends, marriage, and money: The social context of HIV risk behaviour in sub-Saharan Africa.” *Health Transition Review* 7: 361–375.
- Olivier de Sardan, Jean-Pierre, Adamou Moumouni, and Aboubacar Souley. 2000. “L'accouchement c'est la guerre': Accoucher en milieu rural nigérien.” *Afrique Contemporaine* 195: 136–154.
- Scheper-Hughes, Nancy. 1992. *Death without Weeping: The Violence of Everyday Life in Brazil*. Berkeley: University of California Press.
- Van der Sijpt, Erica. 2011. ‘The vagina does not talk’: Conception concealed or deliberately disclosed in Cameroon.” *Culture, Health, and Sexuality* 14(1): S81–S94.
- Van der Sijpt, Erica, and Catrien Notermans. 2010. “Perils to pregnancies: On social sorrows and strategies surrounding pregnancy loss in Cameroon.” *Medical Anthropology Quarterly* 24(3): 381–398.