



UvA-DARE (Digital Academic Repository)

Marginal matters: pregnancy loss as a social event

van der Sijpt, E.

DOI

[10.1016/j.socscimed.2010.03.055](https://doi.org/10.1016/j.socscimed.2010.03.055)

Publication date

2010

Document Version

Final published version

Published in

Social Science & Medicine

[Link to publication](#)

Citation for published version (APA):

van der Sijpt, E. (2010). Marginal matters: pregnancy loss as a social event. *Social Science & Medicine*, 71(10), 1773-1779. <https://doi.org/10.1016/j.socscimed.2010.03.055>

General rights

It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations

If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: <https://uba.uva.nl/en/contact>, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.



Marginal matters: Pregnancy loss as a social event

Erica van der Sijpt*

Amsterdam Institute for Social Science Research, University of Amsterdam, Kloveniersburgwal 48, 1012 CX Amsterdam, Netherlands

ARTICLE INFO

Article history:
Available online 13 May 2010

Keywords:
Cameroon
Pregnancy loss
Reproductive health
Decision-making
Social bodies
Vital conjunctures
Interdisciplinarity

ABSTRACT

Studies on fertility in Africa have known a major paradigm shift when demographic concerns about 'overpopulation' came to be replaced by new ideas about reproductive health, rights, and choices during the 1994 International Conference on Population and Development (ICPD). Whereas this shift has allowed for more recognition of losses during pregnancy which had been virtually absent in previous demographic accounts of high fertility rates, the new discourse on rights and choices turns most of its attention to *induced* loss. Losses that spontaneously occur remain merely bound to the medical realm. Yet this paper shows that for many women in Africa and elsewhere, spontaneous pregnancy loss is a daily life reality which is inherently related to many social affairs, i.e. life and death, illness and suffering, marriage and kinship, the body and personhood. The rather reductionist biomedical discourse prevalent in the global health arena largely ignores these themes and social complexities – thus causing a gap between health policies and daily life realities for women. Drawing on eleven months of anthropological fieldwork in Cameroon in 2004 and 2008, this article explores the way in which socio-cultural insights could contribute to a better understanding of the experiences of women coping with pregnancy loss. The notions of 'vital conjunctures' and 'social bodies' will form an alternative approach to decision-making in case of reproductive mishaps. By applying these concepts to the personal story of an informant, their relevance and contribution to an interdisciplinary discussion on the topic become clear. The author argues for an integration of anthropological expertise in international reproductive health debates and explores how interdisciplinary work could make health policies on reproductive loss less marginal than is the case at present.

© 2010 Elsevier Ltd. All rights reserved.

Introduction

From the 1950s onwards, there has been much international and scholarly attention for 'overpopulation' in African countries, inspired by a concern with the negative consequences of population growth on development and the natural environment in these settings. This attention to high fertility rates has long ignored the situation of women experiencing spontaneous pregnancy loss – being able to conceive, but having problems with carrying pregnancies successfully to term. Yet reproductive loss is a recurrent phenomenon: although occurrence rates are not universal and vary per locality, general estimations suppose that at least ten to fifteen percent of all pregnancies end in a miscarriage (Curtis, 2007). Furthermore, there is a common agreement that the chances of spontaneously aborting a pregnancy increase with age and that one loss increases the risk of losing subsequent pregnancies. 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 (Layne, 1997; Letherby, 1993; London, 2004).

Although there has been increasing acknowledgement of the common occurrence of these reproductive mishaps since the 1994 International Conference on Population and Development (ICPD) – where previous demographic approaches became heavily criticized – current attention to the problem is rather one-sided and overshadowed by other pregnancy-related issues that are considered more pressing – e.g., unwanted pregnancies, induced abortions, or maternal and infant mortality. Even if spontaneous pregnancy loss has become recognized as one amongst many other complications related to maternity, a reduction of attention to its physical problems and management procedures has led to a mere *medicalization* of the experience of reproductive mishaps.

Yet, pregnancy loss is a crucial phenomenon within women's daily social lives; there are many personal stories behind it. Since the ICPD, these stories have become increasingly investigated by medical anthropologists and feminists aiming to 'give voice' to marginalized groups or events that had too long been silenced in normative or technical accounts of reproduction. These scholars

* Tel.: +31 646206705.

E-mail addresses: ericaatje@gmail.com, E.vanderSijpt@uva.nl

seek to contextualize and diversify the unheard voices talking about subjective experiences of reproductive loss in different cultural settings (Cecil, 1996; Erviti, Castro, & Collado, 2004; Gerber-Epstein, Leichtentritt, & Benyamini, 2009; Layne, 2003a, b; Letherby, 1993; Littlewood, 1999; Savage, 1996; Simmons, Singh, Maconochie, Doyle, & Green, 2006). 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 loss in women's daily lives in Cameroon. Through the presentation and analysis of a case-study, it will explore how these daily life realities and socio-cultural insights relate to the scientific and international debates on reproductive health, choice and decision-making. The notions of 'vital conjunctures' (Johnson-Hanks, 2006) and 'social bodies' (Scheper-Hughes & Lock, 1987) will be used to overcome the gap between international reproductive health discourses and daily life realities for Cameroonian women, and to argue for an integration of anthropological expertise in demographic and biomedical studies.

Methodology

The empirical foundation for this article consists of eleven months of anthropological fieldwork, divided over two periods of four and seven months between 2004 and 2008, in an East-Cameroonian village. With around 1000 inhabitants and the presence of several institutional services such as different Christian churches, a kindergarten, a primary and secondary school, as well as a health center with a maternity ward, this village is rather big in comparison to neighboring settlements in this rainforest area. Economic activities are nevertheless mainly informal and comprise agriculture, hunt and petty trade; those formally employed are rare in the village and do mostly reside in the provincial capital 65 km away.

Most of the information was 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 deliveries and abortions, or visiting the market, church and healers with them. Next to the informal conversations which took place during these daily events, formal interviews were held in French with 25 informants. These women were selected through purposive sampling, with the initial help of the president of the women's corporation in the village. The final group of informants 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 upon specific themes, such as embryology, sexuality, kinship, marriage, 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 240 village women who were (or had been) sexually active. This multiplicity of methods yielded detailed information which 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. The life-history interviews were coded in *Atlas-ti* for systematic content analysis.

The analytical insights that I present in this article with regard to the specific case of Sophie were developed during the seven month fieldwork period in 2007–2008. Her particular story was given shape through numerous informal conversations, observations, and six life-history interviews lasting two or more hours each. My subsequent analysis, however, could only evolve through the study of many other cases as well, where similar social processes as the ones described in this article seemed to be at play. The excerpts that are currently presented have been translated from French into English as accurately as possible, with explicit efforts to maintain the specific meanings and emphases of Sophie's words and expressions.

Both during data collection and in the analysis and writing phases, ethical reflections and considerations were dealt with as proposed by research ethics committees – even if a formal ethics committee approval had not been required by the standard procedures to which this research was submitted. Due to the high level of confidentiality and secrecy inherent to the relationships with and experiences of my informants, their explicit permission to interview them and to use a tape-recorder was asked. Further, both during daily happenings and emotionally-laden events, I repeatedly inquired whether my presence as a researcher was allowed and accepted. Data informally gathered through participant observation and presented in this article has been checked on anonymity. Likewise, the real name of my informant has been changed into the synonym of Sophie, in order to prevent any harmful consequences of her willingness to share intimate details with me – and, thus, to make me part of her vital conjuncture of pregnancy loss.

A partial picture of pregnancy loss

International debates on fertility in Africa have long been influenced by demographic concerns with the continent's rapid population growth and the resulting negative consequences for development and the natural environment. This preoccupation with growth rates resulted in a focus on either the many live births that should be diminished through family planning or on deaths of children *after* these live births. Losses *before* birth tended to be ignored in these discussions (Bledsoe & Banja, 2002). After the critique on these demographic imperatives during the 1994 International Conference on Population and Development (ICPD), two intertwined discourses emerged that started to shed new light on reproduction in Africa and elsewhere. Firstly, the core concepts of sexual and reproductive health were developed and situated in a framework of rights, liberty, autonomy and choice. Reproductive health was defined to encompass 'the capability to reproduce and the freedom to decide if, when and how often to do so' (*Program of Action*, paragraph 7.2). Secondly, and relatedly, specific attention came to be paid to the improvement of maternal health and the reduction of child mortality, as specified in the Millennium Development Goals agreed to by 189 countries in 2000.

These new approaches allowed for a more diverse and realistic view of people's reproductive experiences; not only high fertility rates, but also its impediments such as infertility and pregnancy loss did now enter the discussion. With regard to the latter, however, most attention turned to *induced* loss; there has been a growing concern with rights to safe induced abortions and/or appropriate treatment of complications arising from 'unsafe abortions'. From 1993 onwards, post-abortion care (PAC) has been promoted as an effective and integrated public health strategy, meant to cover all forms of pregnancy loss (Corbett & Turner, 2003; Curtis, 2007). However, within this framework *spontaneous* pregnancy loss is only

explicitly mentioned with respect to emergency treatment services – a focus on physical complications and management procedures that leads to a mere *medicalization* of reproductive mishaps. The attention to community participation, counseling and guidance of subsequent reproductive decision-making – that is, the psycho-social aspects of post-abortion care – significantly turns to cases of *induced* loss. The experiences, desires, decisions and future-orientations of women with spontaneous loss – that might be radically different from those who underwent induced abortion – are hardly considered; they remain bound to the medical realm.

This bias towards (unsafely) induced losses might not only be explained by their life-threatening character and thus their central importance in current discussions on maternal morbidity and mortality; it can also be related to a dominant discourse in which reproductive *choice* has become center of attention. With the explicit focus on women's autonomy and rights, more light has come to be shed on consciously enacted and often unsafely performed abortions than on losses that occur spontaneously. However, this choice paradigm reveals some presuppositions that distort the reality of reproductive practices and experiences in different cultural settings. For, the discourse focuses on *rational* and *free informed* choices of *individuals* or *couples* regarding their number of children. To begin with, this projection of calculated rationality is highly problematic in the field of sexuality and reproduction; sexual activities are often spontaneous and reproductive outcomes and desires unanticipated, multiple and changing. Moreover, the focus on individuals and couples does not account for other social relations – as well as their inherent power differences – possibly implicated in reproductive decision-making. Lastly, the discourse tends to point its attention to explicit decisive moments – such as when women clearly *do* or *do not* want a pregnancy. The decisions and practices that come into play at moments when reproductive intentionality is less straightforward – e.g., in case of spontaneous pregnancy loss – are often disregarded.

These shortcomings of the reproductive choice discourse, as well as the concomitant marginalization and medicalization of spontaneous pregnancy loss, lead to a one-sided view of what are in fact socially complex and dynamic experiences of reproductive mishaps that matter in women's daily lives. In the following, I will explore some anthropological concepts that may allow us to capture these realities more comprehensively.

Covering contextuality

One useful approach in the study of pregnancy loss in Cameroon might be the one developed by *Scheper-Hughes and Lock (1987)*. They deconstruct the Western body-mind dichotomy and argue for a more detailed analysis of the body and its inherent relation with surrounding contexts. Rather than viewing the body as a bounded physical entity which serves as a basis for individuality and autonomy, the authors indicate that the body should be seen as a unitary, integrated aspect of self and social relations – a social body. Even more than merely acknowledging the influence of social relationships on subjective experiences, they thus argue that the body and personhood *themselves* need to be reconceptualized as intrinsically socially constituted.

Following this socio-centric conception of the self, health and illness are then not to be situated within body and mind alone, but also within social relationships and the wider political economy. Indeed, these latter are even *inherent to* and *constitutive of* one's well-being – such as when sickness becomes explained or attributed to malevolent social relations, to the breaking of social and moral codes, or to disharmony within families or between communities. Health-seeking behavior in these cases tends to be directed towards collectivized and socially embedded therapies

rather than biomedical models which rely on an individualist notion of physical health. This idea of a social body thus complements – or even criticizes – the above described notion of an autonomous individual that does not do justice to the relational aspects of daily life. It also redefines illness experiences and behavior as situational incidences which can only be understood by grasping the interconnectedness of the social and personal circumstances leading up to and following their occurrence.

Following Scheper-Hughes and Lock, I 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. In Cameroon, as elsewhere, pregnancy forms not only the utmost manifestation of relationships of a woman with a man and a child, but it also symbolizes wider kinship relations – a pregnancy constituting the link between ancestors and future generations of a certain family. This relational perception affects the ways of coping with and giving meaning to misfortune during pregnancy – with losses explained in terms of malevolent interactions of others, for example. Perceiving pregnant women as having social bodies enables us to grasp and understand reproductive notions, behavior and decisions surrounding pregnancy and its loss. It also places reproductive behaviour within temporal and spatial dimensions and shows how experiences change according to different social situations, times and places during a life course.

This attention to the time- and place-bound situatedness of reproductive decisions can be more deeply elaborated by the concept of 'vital conjunctures'. This notion is used by *Johnson-Hanks (2006)* in her study on motherhood in South-Cameroon. It captures the structures, constraints, and possibilities that Cameroonian women encounter when they conceive unintentionally; 'vital conjunctures' are 'socially structured zones of possibility that emerge around specific periods of potential transformation in a life' (2006: 22). First pregnancy and motherhood – and, indeed, reproductive loss – can be defined as vital conjunctures; they are characterized by extreme uncertainty, desirability, potential for radical transformation of reproductive life trajectories and new orientations to the future ('horizons').

These horizons are socially constructed and depend on the specific combination of possibilities and constraints a situation presents to a woman who finds herself pregnant – or, indeed, faced with pregnancy loss. Which steps are finally taken at such a juncture depends upon many specific conditions as well as the surrounding social networks. Here, vital conjunctures and social bodies meet; women's decision-making at uncertain moments of reproductive mishaps is inherently connected with their social relationships – embedded in their social, pregnant bodies. Thus combining the insights of social bodies and vital conjunctures, special attention will be given to the social dynamics that are at play at moments of pregnancy loss, but that are often ignored in the reproductive health discourse and the individualist notion of reproductive choice. I will now turn to those social contexts that are relevant to understand the ideas and practices of women with pregnancy loss in Cameroon.

Social dynamics of village life

In the village where I conducted research, daily activities and social relationships are profoundly shaped by marriage and kinship configurations – two domains of life that are dynamically related to each other. Especially in the past, marriage seemed to be an affair of families rather than individual partners. A conjugal arrangement used to be concluded 'traditionally' through a series of exchanges between both partners' families, whereupon the woman would go and live with her new husband and his relatives. As bride-price

payments to the woman's family would continue, every child she would bear in this marriage would be considered as belonging to the father and his family, i.e. the patrilineage. Even when a woman would decide to leave her husband, her children would stay with their father and his relatives.

Notwithstanding this 'ideal' story, nowadays the payment of the (parts of the) bride-price is often delayed or left out completely. With the onset of the economic crisis in the mid-1980s and the devaluation of the local currency in 1994, village men hardly succeed to accumulate the means to fulfill their bride-price obligations. Consequently, many marriages – especially those of young people – have become 'trial marriages' that are constituted by the mere living, eating and sleeping together of two partners. Bearing children in these informal relationships has become an important strategy for women to prove their fertility and thus convince their unstable partners of their worth. Dissolution of this kind of 'trial marriage' in which bride-price payments are not yet or hardly initiated, only entails the returning of women to their own families, often accompanied by their younger children. Local marriages thus have become informal, fragile and flexible; they offer some freedom to women and men alike (Calvès & Meekers, 1997). At the same time, both gender norms and economic hardships lead to an explicit preference of families to have their daughters married and taken care of ('*encadré*') in a conjugal setting.

Within this context, it is not surprising that unions are rarely asserted at the municipality or in the church. Men especially seem hesitant to deprive themselves of the possibility of taking another wife in the future, since polygyny is a widespread practice. Women mostly express negative views about polygynous households; these would be characterized by jealousy and conflicts between co-wives. At the same time, this 'official' polygynous marriage situation is preferred over the secret extra-marital relationships many husbands maintain – although women themselves also secretly enjoy and assert sexual freedom within conjugal spheres. When children are conceived in these informal relationships – whether they are 'pre-marital' or 'extra-marital' – inheritance becomes an explicit point of contestation.

Kinship relations are, like conjugal relationships, characterized by complexity and flexibility. The dominant kinship idiom is mainly patrilineal: although the roles of both father and mother in procreation are acknowledged, all children – with a preference for sons – are said to ultimately belong to their father, provided that he paid the bride-price for his wife. However, as this tradition is not always adhered to nowadays, opinions about this right differ. Most people insist that even without having transferred a bride-price, every man has the right over his children, as long as he assumes responsibility for them. When a man however does not acknowledge his paternity, a child automatically belongs to and will be raised in his or her mother's family – situations that show that kin relations are flexible and strategic (Notermans, 2004). Behavior with regard to reproduction is not less strategic; experiences and decisions around childbearing, abortions, but also spontaneous losses should be studied within these wider social contexts.

These latter two events occur rather frequently in the village; more than 60% of the 240 women surveyed in 2007–2008 indicated to have lost at least one pregnancy, of which 11% was noted to be voluntarily induced. In reality this percentage might be even higher, since abortion practices tend to be underreported in settings where they are surrounded by immorality and illegality; in Cameroon, article 337 of the penal law condemns voluntary interruptions except for cases in which a pregnancy poses a threat to the woman's life or results from rape or incest. With most pregnancies falling outside these categories, in practice women can only resort to illegal and often unsafe means to abort. Although from 2001 onwards, post-abortion care (PAC) is recognized as an essential

component of women's reproductive health care in Cameroon, the country's health system has – due to the economic crisis, corruption, and other structural problems – deteriorated in such a way that these services are scarcely provided and medicines often out of stock. Many village women who experience pregnancy loss – induced or spontaneous – therefore often resort to self-medication, the informal drug market, or traditional practitioners such as Islamic healers from the North of Cameroon (*marabouts*), healing on the basis of clairvoyance, incantations, mystical powders and natural products.

In the following, I will present a reproductive life-history of one of my informants. This is a story that neither a medical doctor in his consultation room, nor a demographer conducting a survey, would be likely to encounter. Still, it is not an exceptional story; many women told me about similar experiences. It shows how reproductive events that have mostly gone unnoticed by academics and practitioners have special significance in the daily lives of women; it also shows how a concept like reproductive choice as constructed in international debates does not account for stories like these.

From worms to witchcraft: Sophie's story

Sophie was the first person I saw when I arrived for a second fieldwork period in the village. She turned out to become my neighbor for the next couple of months. After some time of usual daily greetings and casual talks, I only got to know her better when I visited her in order to conduct a survey. Asked to tell me about her reproductive history, Sophie said that she had had two miscarriages, one of them being the very reason of her staying with her mother in this village, rather than with her husband in a nearby city. Due to her health problems, she spent whole days at home. I started to visit her from time to time.

During one of my visits, Sophie tells me about the good time she and her husband had had together in the first years of their marriage. When she met him, Sophie had already borne a daughter with another man, whose marriage proposal she had declined. Seeing the 'proof' of her fertility, her husband got interested in her. As he really longed for children at that moment – 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. However, the by then 18-years-old Sophie considered herself too young to bear a second child and unsuccessfully tried to abort the unexpected pregnancy. Her new husband, however, 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, 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 barks [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* medicaments¹ that have treated this for me. 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

¹ Mectizan® is widely used by onchocerciasis and lymphatic filariasis control programs and is freely distributed once a year among Cameroon's population.

worm. When I heard this I decided to take this. 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. The women's worm that Sophie accuses here is reported by many villagers as a major danger to pregnancies. Located in the belly, it is perceived to 'eat' the blood destined to form a fetus after conception – upon which a woman will automatically miscarry. Although this women's worm is not a biomedically acknowledged cause of pregnancy loss, my informants classified it into the category of 'diseases' within local etiology (van der Sijpt, 2007) – meaning that it is a rather 'innocent' cause of loss which can be cured by hospital or indigenous treatments. As this sudden loss had made her husband and in-laws suspect that it was Sophie herself who had induced the abortion – especially as she had been trying to end her previous pregnancy – Sophie had a clear interest to externalize and minimize the cause of her misfortune by exploiting this 'neutral' medical discourse. In order to show her innocence and goodwill, she herself took initiative to seek remedies to kill the worm and conceive again. As she quickly succeeded in this, the incident 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 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' due to the extramarital affair of her husband. Not only was he now absent most of the time, but he also neglected his financial responsibilities towards Sophie and her children. When Sophie found out that her husband was seeing another woman, who was said to have borne a son in this relationship, she felt shocked and disappointed. Her relationship with her husband worsened to the extent that he denied being the father of her 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. In the end, she gave birth to a fourth daughter, just at the moment when her new co-wife moved into the house.

From this time onwards, the many fights between the co-wives made the situation unbearable for Sophie. She ran away several times 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 into marriage. 'Since there were already children, they said it was not good to leave them behind like that'. In fact, a quick return to her marriage was also warranted since her mother was herself trapped in a precarious situation; she had recently lost her husband and lived in her own family again after having been chased away by the sons of her co-wives. Being a 'burden' for her own family, Sophie's mother tried to keep the presence of her daughters as minimal and temporary as possible. 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:

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 30 min 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, 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. 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. I will not bear children anymore.

Although the two miscarriages occurred at similar phases of pregnancy, Sophie's experiences were clearly dissimilar:

There is really a difference. Because the first time, we found out [about the cause], we treated it, and it cured me. I never encountered the problem again. Well, this time, even until now, I still feel the pain. And it remains very warm inside. I don't know. Doctors say it is typhoid. They prescribed five examinations, but I don't have the means to undergo all of them. Just the problem of money. I would like to start with the hospital and finish these examinations. And then, I will go and see ahead. Because she [her co-wife] practices day and night and she succeeds in it. And I only practice during the day. I searched for indigenous medicines here in the village, but that doesn't work well. It tends to help a bit and then it releases again. So I want to go to a *marabout*. They will tell me everything. Everything that she [her co-wife] is doing. You will hear it. No, [I will] not go back into this marriage. I only want my health.

The relationship between Sophie and her co-wife is, like in many other polygynous households in this region, characterized by competition, jealousy, and witchcraft accusations. With both women competing for their husband's attention, money, and care – which are best assured through childbearing – accusations of the other's 'nightly practices' – i.e. witchcraft attacks – are prone to develop and to focus on reproductive capacities. Despite her initial reluctance with regard to this pregnancy, Sophie quickly interpreted its sudden disruption in this particular situation as yet another misfortune adding to all adversities that had befallen her lately. Since the other problems were brought about by the new co-wife, a logical step was to think of this miscarriage as also caused by 'this devil, whose only purpose is to destroy', as Sophie calls her husband's lover. Her suspicions were reinforced by the unexplainable and enduring physical complaints after her miscarriage; these must surely be due to enduring witchcraft practices against her. In this case, an indigenous healer was the only one to be consulted in order to see what was 'really' underlying this reproductive mishap.

Indeed, visiting a healer proved to be a turning point in Sophie's illness episode. Through clairvoyance, it was confirmed that her co-wife practiced witchcraft in order to destroy Sophie's health and conjugal future. Remedies were given not only to restore Sophie's health and childbearing capacity, but also to make her husband listen to her again and to let the effects of the co-wife's harmful remedies work out on the co-wife herself instead of Sophie. When I left the field, Sophie was happy and hopeful about this treatment: her physical ailments were disappearing, she was able to work on

the fields again, and her husband was finally willing to listen to the proposals of her negotiating mother. She intended to go back to the city soon and live in a separate apartment, far away from her co-wife.

Etiologies and embryologies: Socially shifting subjects

Sophie's two incidents of pregnancy loss which were clearly expressed to be differently experienced, happened in radically different social contexts. In the first instance, Sophie had been the center of the attention of her husband who was impatiently waiting for the children she would bear and already showed his serious intentions by transferring gifts to Sophie and her family. Getting pregnant in this beginning phase of marriage was desirable for Sophie; miscarrying immediately raised suspicion among her husband and in-laws. During her second miscarriage, the situation was almost the reverse: her husband had turned his attention to another wife and he did not care about Sophie's childbearing capacities anymore; he neglected Sophie and her family financially; Sophie's ambitions of a future formal marriage had been destroyed by the coming of the new co-wife; and getting pregnant was something that she initially did *not* hope for. Miscarrying now raised her own suspicions.

In both instances, the cause of pregnancy loss was externalized and the self depicted as a sufferer, but with different connotations: where the first loss could be minimized by exploiting a 'neutral' medical discourse on an innocent worm picking in the belly, for the second one simplistic, naturalistic explanations – like the typhoid diagnosis – were not longer adequate but were replaced, or at least complemented, by personalistic accounts of the witchcraft practices of the co-wife. Biomedical help was still believed to be effective for physical complaints, but could not do away with the *metaphysical* causes; as long as the *social* body would remain out of balance, the *physical* body could not entirely be cured. In the light of this social conception of illness and its situationally shifting etiology, the intermingling of biomedical and local healing methods – which was discernable in the life histories of many other informants and has been abundantly described in other studies as well (Davies, 2006; Hollenberg, 2006; Maynard, 2003) – makes perfectly sense for Sophie.

Together with a shifting etiology, there is also a shifting view on embryology that makes this second incident much more consequential. Note that this time, the conceptualization of what has been lost in an early miscarriage is not anymore negligibly described as 'only water', but is considered a potential child and even the loss of childbearing capacity more in general – reflected in the worry 'I will not bear children anymore'. Definitions of the pregnant body and what it carries – whether it is conceived as a fetus's body or not – are inherently dependent on social circumstances. Thus, in contrast to rather fixed biomedical definitions of embryology and etiology, local conceptions of two losses happening at the same phase of pregnancy are flexibly shifting from a worm eating some insignificant liquids in the body towards a witch trying to destroy a developing person. Different interpretations then lead to different experiences of pregnancy loss; which interpretation is considered plausible depends on the social situation the woman finds herself in at the moment of miscarriage.

Indeed, not only are the etiological and embryological *explanations* radically different in these changing social circumstances, but also Sophie's bodily *experiences*: in contrast to the first incidence of loss, Sophie's narrative of the second experience heavily laments her physical suffering and pain that seem to linger on and on – just as her relational problems seem rather insurmountable and irreversible. Social pain and disorder thus lead to physical pain and disorder; the latter in turn allow for a reflection on the former. The direct link

between the last two sentences in Sophie's narrative – 'I will not go back into this marriage. I only want my health' – indeed highlights the relevance of the concept of social bodies in trying to understand experiences of pregnancy loss. Not only does it shed new light on Sophie's complaints, but it also allows for new insights on ensuing health care decision-making. For, not only bodies, but also decisions are often socially constituted in cases of pregnancy loss.

Changing chances and choices

In Sophie's narrative, several persons can be detected who influenced, if not directly her bodily experiences, then certainly her reproductive decisions surrounding the losses. These persons themselves were in turn influenced by their specific (positions within) surrounding social networks. For instance, Sophie's husband, being the unique son in his family, was not only encouraged by his parents to search for – and pay bride-price transactions to the family of – a fertile wife, but also turned out to be heavily influenced by his mother to engage in extra-marital affairs in order to search for more children – preferably sons. His change in attitude drastically affected Sophie's stakes during her two instances of loss. Her sister and mother turned out to be of major importance at decisive moments as well; they convinced Sophie to marry with this well-to-do husband and to resign to the fact that she had to bear a lot of children; they inhibited her abortion intentions; and – although supporting her in her health-seeking efforts – they tried to negotiate with the husband and force Sophie to go back in the marriage. The death of Sophie's father which had drastically affected the situation of her mother, in turn influenced Sophie's horizons and pathways. Her decisions are thus largely influenced by a circle of kin and in-laws who, themselves situated within their respective socio-economic environments, all have stakes in her reproductive outcomes. They play a role in directions taken at moments of uncertainty when future perspectives become disrupted.

And both instances of loss were exactly that for Sophie; they formed situations of extreme uncertainty and potentiality for transformations of her life trajectory – pregnancy loss as a 'vital conjuncture'. When Sophie miscarried for the first time, it was in her interest to conceive quickly in order to prevent her still precarious marriage relation from ending. 'Horizons' were opening up for Sophie by the distribution of *mectizan*, medical advice, and the strong desire for children of her husband and in-laws that she eagerly sought to fulfill. In the second situation however, horizons within the conjugal sphere were closed down and also the hospital could not offer anymore what was wanted in this situation. Instead, leaving the marriage, receiving support from her mother and sisters, consulting an indigenous healer, and probably also meeting an anthropologist who would listen to her, were alternative horizons offering new paths to the future for Sophie.

These specific horizons and the ensuing decisions are influenced by both wider *societal norms* and *practical configurations*. Sophie's decisions and those of social others surrounding her, while shown to be often mutually intertwined, also need to be set against the background of existing normative frameworks about womanhood and motherhood, about relationships with men and elders, and about the meanings of kinship and marriage. Further, both social practices and norms are given shape within wider economic and political configurations which in practice lead to daily financial insecurity for both men and women, deteriorating and unreliable public health services and a corrupt political atmosphere where patrimonialism has pervaded even the most intimate domains of life. Sophie's strategies with regard to marriage and health-seeking, her mother's insistence of continuation of this particular alliance, her husband's extra-marital escapades, his lover's efforts to enter the house, and his mother's influence in this arrangement – which

all affect the way Sophie makes sense of her reproductive mishaps – should be comprehended within these wider frameworks and the horizons that they do or do not create to all of the social players involved.

Thus, if we really want to explore Sophie's 'reproductive choices', then we should be attentive to this opening up and closing down of horizons in different situations with different social actors involved and with different norms and configurations at play. The vital conjunctures of pregnancy loss have been shown to be constantly shifting; fixed and individualist conceptions of the event and its concomitant decision-making as conceptualized by biomedicine and demography can not capture the social dynamics that underlie the stories of Sophie and many others.

Prospects for policies

The description and interpretation of Sophie's story – although tentative – shows how the anthropological narrative approach sheds new light on experiences of pregnancy loss. Personal accounts like the one of Sophie illustrate how local reproductive notions and experiences diverge from a rather technical international attention to, and discourse on, reproductive mishaps. They provide information that has long been overlooked by demographers focusing on numbers of births, or by biomedical researchers and practitioners considering all instances of loss as similar biological events which can be treated in a standard way.

A detailed anthropological perspective thus provides insights where the technical discourse reaches its limits; it shows how the *physical* event of pregnancy loss is always taking place in *social* worlds and is thus imbued by social meanings. The notions of vital conjunctures and social bodies take this duality into account; they both allow for the integration of physical and social aspects of reproductive behaviour and suffering. The social body, without discarding the materiality of physical experiences, draws attention to its inherent social aspects as well; vital conjunctures offer a space to explore how both physical needs or constraints and socially constructed wishes, options or restrictions influence reproductive behavior. Through this socio-centric approach, pregnancy losses emerge as heterogeneous rather than homogeneous, and situational rather than universal events.

Likewise, reproductive decision-making appears to be socially constituted rather than autonomous and free of context. The notions of vital conjunctures and social bodies further highlight how certain situations are initially *not* chosen, how choices are *not* made or not possible to make, how certain options are explored but absconded again, or how people feel forced to take certain decisions due to interactions with other social actors. Not only do these concepts thus allow for an in-depth exploration of reproductive experiences that have long been neglected, quantified or medicalized, but they also provide alternatives for the notions of body, autonomy and choice underlying current reproductive health debates and policies.

If, since the ICPD, the aim of these reproductive health policies is to be more attentive and relevant to experiences – both physical and social – of pregnancy loss, and if the aim of biomedical services and post-abortion care is to provide optimal integrated support in cases of pregnancy loss, an interdisciplinary approach which takes into account social dynamics and local conceptions is indispensable to reach these goals. On the policy level, this would mean that anthropological insights like the ones generated in this article could be used to inform policy makers, researchers, and program developers to ensure comprehensive policies and culturally relevant projects. On the service level, health care providers would profit from interactions with local anthropologists or from trainings on cultural competence in order to better understand their clients' service needs and expectations.

Indeed, greater attention to the processes leading up to and following pregnancy loss as proposed in this article offers policy makers and practitioners a more comprehensive view of the event than the mere attention to emergency treatment services as currently defined in post-abortion care; it is needed to improve the quality and range of these policies and services. Furthermore, it encourages a critical reflection on current hegemonic discourses on reproductive health and decision-making, and could initiate a discussion on how to integrate structural inequalities and social dynamics into rhetorics of choice and care. Finally, it gives voice to women whose perspectives on marginal health issues have only been marginally considered. Only by listening to stories like Sophie's can we improve our understanding of what is really at stake for people who refrain from complying to biomedical treatments or post-abortion care in certain circumstances.

Acknowledgements

I would like to thank the participants of the interdisciplinary workshop 'Loss in childbearing in Sub Saharan Africa and South Asia', held in Edinburgh in September 2008, as well as anonymous referees, for their valuable comments.

References

- Bledsoe, C. H., & Banja, F. (2002). *Contingent lives: Fertility, time, and aging in West Africa*. Chicago, IL: University of Chicago Press.
- Calvès, A. E., & Meekers, D. (1997). The advantages of having many children for women in formal and informal unions in Cameroon. *CEPED Series*, 3, 617–639.
- Cecil, R. (1996). *The anthropology of pregnancy loss: Comparative studies in miscarriage, stillbirth, and neonatal death*. Oxford, UK, Washington, D.C: Berg Publishers.
- Corbett, M. R., & Turner, K. L. (2003). Essential elements of postabortion care: origins, evolution and future directions. *International Family Planning Perspectives*, 29, 106–111.
- Curtis, C. (2007). Meeting health care needs of women experiencing complications of miscarriage and unsafe abortion: USAID's postabortion care program. *Journal of Midwifery and Women's Health*, 52(4), 368–375.
- Davies, J. (2006). The anthropology of aetiology. In: *Bordering Biomedicine*, p. 49.
- Erviti, J., Castro, R., & Collado, A. (2004). Strategies used by low-income Mexican women to deal with miscarriage and spontaneous abortion. *Qualitative Health Research*, 14(8), 1058–1076.
- Gerber-Epstein, P., Leichtenritt, R., & Benyamini, Y. (2009). The experience of miscarriage in first pregnancy: the women's voices. *Death Studies*, 33(1), 1–29.
- Hollenberg, D. (2006). Uncharted ground: patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings. *Social Science & Medicine*, 62(3), 731–744.
- Johnson-Hanks, J. (2006). *Uncertain honor: Modern motherhood in an African crisis*. Chicago: The University of Chicago Press.
- Layne, L. L. (1997). Breaking the silence: an agenda for a feminist discourse of pregnancy loss. *Feminist Studies*, 23(2), 289–316.
- Layne, L. L. (2003a). *Motherhood lost: A feminist account of pregnancy loss in America*. New York: Routledge.
- Layne, L. L. (2003b). Unhappy endings: a feminist reappraisal of the women's health movement from the vantage of pregnancy loss. *Social Science & Medicine*, 56(9), 1881–1891.
- Letherby, G. (1993). The meanings of miscarriage. *Women's Studies International Forum*, 16(2), 165–180.
- Littlewood, J. (1999). From the invisibility of miscarriage to an attribution of life. *Anthropology & Medicine*, 6(2), 217–230.
- London, S. (2004). Poor outcome in first pregnancy may predict stillbirth in second one. *Perspectives on Sexual and Reproductive Health*, 3, 133–134.
- Maynard, K. (2003). *Making kedjom medicine: A history of public health and well-being in Cameroon*. Westport, Conn: Praeger.
- Notermans, C. (2004). Sharing home, food, and bed: paths of grandmotherhood in East Cameroon. *Africa*, 74(1), 6–27.
- Savage, O. M. N. (1996). 'Children of the rope' and other aspects of pregnancy loss in Cameroon. In R. Cecil (Ed.), *The anthropology of pregnancy loss: Comparative studies in miscarriage, stillbirth, and neonatal death* (pp. 95–107). Oxford, UK, Washington, D.C.: Berg Publishers.
- Scheper-Hughes, N., & Lock, M. M. (1987). The mindful body: a prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly*, 1(1), 6–41.
- Simmons, R. K., Singh, G., Maconochie, N., Doyle, P., & Green, J. (2006). Experience of miscarriage in the UK: qualitative findings from the National Women's Health Study. *Social Science & Medicine*, 63(7), 1934–1946.
- van der Sijpt, E. (2007). Marginal motherhood. The ambiguous experience of pregnancy-loss in Cameroon. Tijdschrift over gezondheid en cultuur. *Medische Antropologie*, 19(2), 245–268.