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MARGINAL MATTERS:

Pregnancy loss as a social event

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ABSTRACT

Since the 1950s there has been much international and scholarly attention for both 'high fertility rates' and experiences of infertility in African cultures that are considered to be pronatalist. Conversely, little light has been shed on the marginal 'in-between' situation of women experiencing reproductive loss, that is: being able to conceive, but having problems with carrying pregnancies successfully to term. Yet this paper shows that pregnancy-loss is a daily life reality for many women in Africa and elsewhere; moreover, it is a phenomenon that is inherently related to many social affairs, i.e. life and death, illness and suffering, marriage and kinship, the body and personhood. However, in health policies a rather reductionist biomedical discourse prevails in which these themes and social complexities are neglected – causing a gap between health policies and daily life realities for women. Drawing on long-term anthropological fieldwork conducted in Cameroon, this paper 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 demographic and biomedical studies and explores how interdisciplinary work could make health policies on reproductive loss less marginal than is the case nowadays.

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INTRODUCTION

From the 1950s onwards, there has been much international and scholarly attention for, on the one hand, ‘overpopulation’ or ‘high fertility rates’ in African countries; and, on the other hand, experiences of infertility in these so-called pronatalist cultures. Many studies have investigated the ideological values, economic costs and social benefits of having many children in African settings, as well as the stigmatization and material deprivation of women who are not able to live up to this ideal (Boerma & Mgalla, 2001; Calvès & Meekers, 1997; Gerrits, 1997; Inhorn, 1994, 1996; Inhorn & van Balen, 2002; Leonard, 2002; Nana-Fabu, 2001; Richards, 2002; Sandelowski, 1990; Wakam, 1992). Due to this attention to both high fertility rates and experiences of infertility in African countries, for a long time relatively little light has been shed on the situation of women experiencing the ‘in-between’ situation of reproductive loss – being able to conceive, but having problems with carrying pregnancies successfully to term. Yet spontaneous pregnancy 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 during the last decade there has been increasing acknowledgement of the common occurrence of these reproductive mishaps, international 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 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 1990s, these stories have become increasingly investigated by medical anthropologists aiming to ‘give voice’ to marginalized groups or events that had too long been silenced in normative or technical accounts of reproduction. These anthropologists

seek to contextualize and diversify the unheard voices talking about subjective experiences of reproductive loss in different cultural settings (Cecil, 1996; Erviti et al., 2004; Layne, 2003; Letherby, 1993; Littlewood, 1999). 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. It will take the daily life realities of women coping with loss in childbearing as a starting point and explore –through the presentation and analysis of a case-study- how these 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 between 2004 and 2009 in an East-Cameroonian village. 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, or visiting the market, church and healers with them. Next to informal conversations that took place during these daily events, formal interviews were held with 25 informants. These centered upon specific themes or life-histories and were recorded and transcribed verbatim. Several other 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. The longitudinal character of this study yielded detailed information which allowed for a thorough exploration of the complexity and diversity of pregnancy loss. The analytical insights that I present in this article with regard to the specific case of Sophie thus only evolved 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.

A PARTIAL PICTURE OF PREGNANCY LOSS

International debates on fertility in Africa – expressing an explicit demographic preoccupation with its population growth – have long been focusing either on live births that should be diminished through family planning projects or on deaths of children *after* these live births. Consequently, losses *before* birth tended to be ignored in these discussions (Bledsoe et al., 2002). Only when feminists came to criticize the demographic attempts to control population – especially during the 1994 International Conference on Population and Development (ICPD) – the core concepts of sexual and reproductive health as well as reproductive *choice* were introduced. Women’s right to reproductive autonomy became an integral part of reproductive health, which 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).

With this new approach, these feminists also started to think of loss during pregnancy. Most attention was turned to *induced* loss; there was a growing concern with (rights to) safe induced abortions and/or appropriate treatment of complications arising from ‘unsafe abortions’.¹ 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. However, *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 and the prevention of unwanted pregnancies through family planning education. The experiences, desires, decisions and future-orientations of women with unwanted 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 and pressing character; it can also be related to a more general

¹ Unsafe abortions are defined by the World Health Organization (2003) as ‘any procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both’.

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 'trivial' spontaneous losses. 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 regarding the number of children, made *before* conception by *individuals* or *couples*. To begin with, this projection of calculated rationality is highly problematic in the field of sexuality and reproduction. Then, the attention is explicitly turned to choices *before* conception, not *afterwards* – i.e., during pregnancies, when losses might occur or be consciously enacted. Further, it is presumed that once people have decided to have another child, they will automatically attain their goal and conceive and bear a child. Moreover, the focus on individuals and couples does not account for other social relations – such as with kin and in-laws - possibly implicated in reproductive decision making. What is more, the assumption of a harmonious couple acting on the basis of shared interests overlooks unequal power and gender relations (Brand, 2001; Watkins, 1993).

These inherent shortcomings of the reproductive choice discourse, together with the demographic quantification and the medicalization of reproductive mishaps, lead to a one-sided view of what are in fact socially complex and dynamic experiences of pregnancy loss that matter in women's daily lives. In order to capture these realities more comprehensively, I will now introduce some anthropological concepts that allow for a different view on reproductive mishaps.

COVERING CONTEXTUALITY

An approach that might prove useful in the study of daily life realities of women with pregnancy loss in Cameroon is the one developed by Scheper-Hughes & Lock (1987). They deconstruct the Western assumption of a body-mind dichotomy and argue for a more detailed analysis of the body and its relation with surrounding contexts. Rather than viewing the body as a bounded physical entity that serves as the basis for individuality, the authors indicate that the body should be seen as a unitary, integrated aspect of self and social relations – a social body. This idea of a social body complements – or even criticizes - the above described notion of an autonomous

individual that does not do justice to the relational aspects of daily life. Especially with regard to health and illness, social relations are often understood as a key contributor to individual experiences. Illness cannot be situated in the individual mind or the body alone, but should be studied within the patient's socio-cultural environment and its more general political economy (Kleinman, 1988; Kleinman et al., 1997). In contexts where a socio-centric rather than an individualistic conception of the self prevails, bodily health is furthermore often perceived as dependent on, and vulnerable to, the wishes and actions of others. Accordingly, sickness becomes explained or attributed to malevolent social relations, to the breaking of social and moral codes, or to disharmony within the family or village community. Therapies in these cases tend to be collectivized as well (Scheper-Hughes & Lock, 1987).²

With regard to pregnancy loss, 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. Not only is pregnancy 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. It matters whether a woman is living among her own kin or her in-laws; her decisions also depend on the stage of the marriage process, the number of earlier (un)successful pregnancies and other socio-historical circumstances.

This attention to the time- and place-bound situatedness of reproductive decisions can be more deeply elaborated by another concept that is useful in studying pregnancy loss: 'vital conjunctures'. This notion is used by Johnson-Hanks (2006) in her study on motherhood in South-Cameroon. It captures the structures, constraints, and

² As recent works questioning the view of a Western autonomous individual have shown – see for instance Carsten (2000; 2004) - we should be careful with a rigid dichotomy between individualistic and socio-centric in terms of Western and non-Western. Although my argument about the inherent sociality of pregnant bodies might be applicable to many other cultural settings, it especially pertains to contexts with an explicit focus on relational selves, such as Cameroon.

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 influence which choices are being made and which possibilities taken. In short, vital conjunctures are ‘manifestations at once of recurring systemacity and of unique possibility and future-orientation’ (Johnson-Hanks 2006: 24).

This unique possibility is made up by the particular situation of a woman who finds herself pregnant – or faced with a pregnancy loss - and the specific combination of horizons, choices and constraints this situation presents. 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 disruption 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 instead of individual partners. A conjugal arrangement used to be concluded ‘traditionally’ through a series of exchanges between the family of the man and the family of the woman, 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 and to go back to her own family, 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 encounter more and more difficulties 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; Meekers & Calves, 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 expressed 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 extramarital relationships many husbands maintain – although women themselves also secretly enjoy and assert sexual freedom within conjugal spheres (Notermans, 1999). 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

within current economic hardships, 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 is recognized to be their father. 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, just as conjugal relations, are flexible and strategic (Notermans, 2004a, 2004b). Behavior with regard to reproduction is not less strategic; experiences and decisions surrounding childbearing, abortions, but also spontaneous reproductive mishaps should be studied within these wider social contexts.

While they are extremely frequent in daily life³, abortions remain neglected in national policies. Cameroon's abortion law is very restrictive; article 337 of penal law only allows voluntary interruptions when 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 them – using dangerous methods or seeking help from medical health personnel or traditional healers who ask large amounts of money for it. 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. In the village, therefore many women who experience pregnancy loss – induced or spontaneous – resort to indigenous healers, self-medication with natural products, or the informal drug market.

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.

³ Answers to a questionnaire show that 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.

FROM WORMS TO WITCHCRAFT: SOPHIE'S STORY⁴

Sophie was the first person I saw when I arrived in the village in East Cameroon where I would conduct my fieldwork and she turned out to become my neighbor for the next couple of months. After usual daily greetings and casual talks for some months, 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 being in the village, living with her mother instead of with her husband in a nearby city. As she was experiencing health problems, she stayed at home all day and I decided to visit her from time to time.

During one of my visits, Sophie starts telling me about the good time she and her husband had had together in the first years of their marriage. When she met her husband, Sophie had already born a child 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 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 worm⁵ 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* medicaments⁶ that have treated this for me. I went to the hospital to ask if the *mectizan* that we should take, would only kill simple

⁴ The name of Sophie is a synonym.

⁵ My informants noted several forms of women's worms. The 'bad' worm that is mentioned here is located in the belly and 'eats' the blood destined to form a fetus after conception. A woman will eventually miscarry.

⁶ Mectizan® is widely used by onchocerciasis and lymphatic filariasis control programs and is freely distributed once a year among Cameroon's population.

worms. They told me that it even kills the women's worm. When I heard this I decided to try 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.

Sophie's next pregnancy somewhat alleviated the suspicion that the sudden loss had raised and secured her position – that was still precarious because of the former conflict between her and her husband's childbearing intentions. Since bride-price transactions were 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 extra-marital 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 burden of her daughter as minimal and temporary as possible. Sophie thus foresaw an unpreventable return to her husband and secretly started taking contraceptive injections in order to

prevent another pregnancy from him.⁷ 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 looked at it and I said: shit. I stayed for at least thirty minutes in the WC because the blood was flowing. Then, I stood up, went to the house and changed my clothes. In all this, my husband was there. But he neglected, 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. Because when I ask him: 'what could be the cause of all this? When it leaves like this [spontaneously]? I do not even work hard like women in the village, because we are in the city. So what is it?', then he only says I should go to the hospital. There, they 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. She destroyed the child in my belly and might possibly also poison my children that I left behind in their house. But my husband does not care about the situation. It is this woman who charmed him.

At first glance, these two experiences of miscarriages as described by Sophie seem to be very similar. Both incidents occurred at the beginning stage of pregnancy and physical complaints are described in a comparable way. However, asked if she experiences a difference between these two cases of early pregnancy loss, Sophie responds:

Yes, 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. I went to the hospital and the doctor examined me. They say it is typhoid. They prescribed five examinations, but I don't have the [financial] means at the moment 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.⁸ 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 what I

⁷ She took Depo Provera® injections – a method that is highly preferred to contraceptive pills in the region.

⁸ The distinction between day and night refers to activities by non-witches and witches respectively.

want is to go to a *marabout*.⁹ 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.

Thus, Sophie's two incidents of pregnancy loss - happening in radically different social contexts - were differently experienced. In the first instance, Sophie had been the center of her husband's attention who was impatiently waiting for the children she would bear. He and his parents already showed their serious intentions by transferring gifts to Sophie and her family; a future with this man seemed promising. Getting pregnant in this situation was desirable for Sophie, because 'when everybody knows that you're married and living with a man it is good to bear a lot of children'. Miscarrying in this beginning phase of marriage however raised suspicion among her husband and in-laws that it was Sophie herself who had induced the abortion – especially as she had been trying to end her previous pregnancy. Faced with this insecurity and distrust, it was in Sophie's interest to externalize the cause of her misfortune by exploiting a 'neutral' medical discourse¹⁰, as well as to get pregnant as soon as possible. She herself took initiative to go and seek remedies to kill the worm and conceive again, in order to show her 'goodwill' towards her husband and his relatives, as they had been doing to her and her family as well. In this, she was backed up by her family, who appreciated the bride-price transaction in economically scarce periods. 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 one month which contains only water'.

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 (even to the extent that he denied being the father of her previous pregnancy, which is highly uncommon within the local context of marriage and especially with a husband known to be in desperate search for children); 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 in such a situation felt

⁹ A *marabout* is an Islamic healer, often practicing on the basis of clairvoyance or incantations from the Koran and healing with natural products and powders. *Marabouts* in this Christian region are often coming from the Islamic North of Cameroon and regularly consulted by local people.

¹⁰ Although the women's worm is not a biomedically acknowledged cause of pregnancy loss, it belongs to a category of causes in local etiology that was labeled 'diseases' by women in my study. See my earlier article (van der Sijpt, 2007) for a more elaborate discussion on the local etiology.

like a misfortune adding to the other misfortunes that had befallen Sophie lately.¹¹ As the other unwanted transformations were brought on by the new co-wife, a logical step was to think of this miscarriage as also caused by ‘this devil, whose purpose is only to destroy’, as Sophie calls her husband’s new lover. Again, the cause of pregnancy loss was externalized and the self depicted as a sufferer, but with different connotations: simplistic, naturalistic explanations – like the typhoid diagnosis – were not longer adequate but were replaced, or at least complemented, by personalistic accounts of the evil doings 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 this case, an indigenous healer was the only one to be consulted in order to see what was ‘really’ underlying this reproductive mishap – an interesting intermingling of biomedical and local healing methods that has been found in numerous other studies as well (Coronado, 2005; Davies, 2006; Hollenberg, 2006; Maynard, 2004).

Together with a shifting etiology, there is also a shifting view on ethno-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 to bear children anymore’. Thus, in contrast to rather fixed biomedical definitions and etiological notions of miscarriage, local conceptions of two losses happening at the same stage 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 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.

It is here that notions of vital conjunctures and social bodies prove insightful to explore the variety of experiences surrounding pregnancy loss – a variety that is often not acknowledged by biomedical sciences nor demographic investigations. The story of Sophie shows first of all how her physical health is perceived as being dependent

¹¹ The fact that Sophie did not want to get pregnant, but at the same time lamented the loss of this pregnancy seems paradoxical, but shows how perceptions and expectations during the antenatal period are constantly shifting. See further Jones (2001) for a more elaborate discussion on multiple and indeterminate hopes surrounding pregnancies.

on, and vulnerable to, the actions of others. For instance, etiological explanations change from naturalistic to personalistic when her conjugal environment turns from encouraging, attentive and hopeful to hostile, negligent and distrustful. Not only are *explanations* radically different in these social circumstances, but also the 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. 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' – indicates the relevance of attention to social bodies in cases of reproductive mishaps.

Consequently, reproductive decisions are not so much individually taken, but rather socially constituted. Sophie's husband, being the only son of his parents, 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. For Sophie, her sister and mother turned out to be of major importance at decisive moments; 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 reproductive decisions are thus largely influenced by a circle of kin and in-laws who all have stakes in her reproductive outcomes.

Second, both instances of loss are shown to be situations of extreme uncertainty and potentiality for transformations of Sophie's life trajectory; pregnancy loss as a 'vital conjuncture'. When Sophie miscarried for the first time, the continuation of her marriage seemed to be in danger by the suspicion the loss had risen. If she wanted to stay in this marriage – which she, and especially her family, did - she would have to prove her innocence and goodwill by quickly getting pregnant again. '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. Indeed, visiting a healer with me proved to be a turning point in Sophie's illness episode. Here, it was confirmed that her co-wife practiced witchcraft in order to destroy Sophie's health and conjugal future. The healer promised to help Sophie in three ways: she would restore Sophie's health and childbearing capacity; she would undo the effect of the co-wife's harmful remedies for Sophie and instead let them work out on the co-wife herself; and she would make her husband listen to Sophie again. When I left the field, Sophie was happy and hopeful about this treatment: her physical ailments were disappearing, she was able to go to the fields again and begin with some commerce, and her husband was 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.

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. 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.

POLICY PROSPECTS

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 show how local reproductive notions and experiences diverge from a rather technical international attention to, and discourse on, loss in childbearing. Reproductive losses emerge as heterogeneous rather than homogeneous events and reproductive decision-making seems to be socially constituted and rather 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

because of interaction with other social actors. Not only do they 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 reproductive health debates and policies.

In this way, a detailed anthropological perspective complements a biomedical one and provides insights where the technical discourse reaches its limits; it shows how the experience of pregnancy loss is not only *physical* but also *social*. Reproductive disruptions are therefore especially suitable to interdisciplinary investigation. Where medical scientists are able to shed light on physical needs of women who suffer from loss during pregnancy, anthropologists and other social scientists could demonstrate that this biomedical paradigm is just one among many other cultural frameworks – all with their own suppositions about the relevance, prevention and treatment of loss in childbearing. These other cultural systems might have different frames of reference which influence people's experiences of disruption. The *physical* event of pregnancy loss is always taking place in *social* worlds and 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. At the same time, these concepts remain broad enough to transcend cultural particularities - and thus facilitate interdisciplinary discussions at a higher level. Where social bodies argue for a more inclusive vision of the body in general, vital conjunctures allow for a broader discussion of the socio-cultural mechanisms and patterns of reproductive decision-making surrounding pregnancy loss. Consequently, reproductive loss becomes conceptualized as a social event that transforms life-courses and opens up or closes down social horizons – irrespective of the personal and cultural variations that these life-courses and horizons might entail. It is not about how all reproductive choices and experiences are the same, but about a process, 'the same no matter where it occurs, in which variations in conditions create variations in results' (Becker 1998: 142).

This attention to the processes before, around, and after pregnancy loss offers a more comprehensive view of the event than the mere attention to emergency treatment services as currently defined in post-abortion care. If, since the ICPD, the aim of 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; it improves our understanding of what is at stake for people as Sophie who refrain from complying to biomedical treatments or post-abortion care in certain circumstances.

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