

## Marginal motherhood

### The ambiguous experience of pregnancy-loss in Cameroon

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*There has been much international and scholarly attention for, on the one hand, 'over-population' or 'high fertility rates'; and, on the other hand, experiences of infertility. Little light has been shed, however, 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. It is the experiences and decisions of those women who do not immediately attain high fertility rates, but are not infertile either that will be at the centre of this study. Based on anthropological fieldwork in East Cameroon in 2004-2005, this article places the experiences of these women within their social contexts by first describing the relevant fields of gender, kinship and marriage in the village of Ndemba I and exemplifying their significance through a personal illness narrative. It then discusses the two major themes that were explored through participant observation, interviews, free listing and pile sorting: the perceived causes and the social consequences of pregnancy-loss. By understanding both the aetiology of and the help-seeking behaviour after pregnancy-loss in the light of the given contexts in the village, it becomes clear that the lives of women who experience pregnancy-loss are characterized by marginality and ambiguity. Not only are their status as a woman and the status of the foetus as a person contested; pregnancy-loss itself is also a phenomenon that is surrounded by doubts and suspicion. It is however this ambiguity that leaves some free room for manoeuvring and enables women to aspire certain ambitions that might run counter the patriarchal ideal of bearing many children. Thus, this article shows that the generally assumed distinction between wanted and unwanted pregnancies or unintended and intended losses – that is, abortions – becomes blurred within the ambiguous dynamics of the prenatal period. It argues that both suffering and agency are dialectically connected within the marginal phenomenon of pregnancy-loss.*

*[pregnancy-loss, abortion, Cameroon, aetiology, help-seeking behaviour, ambiguity, suffering, agency]*

From the 1950s onwards, population and fertility issues have gained much international attention. On the one hand, demographic statistics and trends warned for and

still predict an enormous global population growth due to high fertility levels in non-Western countries<sup>1</sup> – especially on the African continent, where the fertility rates in many countries average more than five live-born children per woman (Bosch 2005). Many studies therefore investigate the ideological value of having many children in African cultures, as well as the material poverty it enhances. On the other hand, research has been conducted on the experiences of women who do *not* bear children in these settings. Following from the assumption that women in many African cultures are only fully respected when they have many children, these studies stress the stigmatization and social as well as material deprivation of women who are not able to conceive.<sup>2</sup>

Due to this attention to either high fertility rates or experiences of infertility in African countries, 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. Even in demographic and medical literature, the classification of women who have experienced pregnancy but not a live birth is contested (Jejeebhoy 1998). Demographers do take reproductive loss into account when defining *primary infertility* as the inability to bear any children during a period of five years, either due to the inability to conceive or due to the inability to carry a pregnancy to a live birth. In medical studies, however, the same concept of primary infertility is usually defined more narrowly as the inability to conceive within two years of exposure to pregnancy. Thus, unlike the demographical classification, this epidemiological definition – that is recommended by the World Health Organization as well – does not include phenomena as miscarriages and stillbirths. Nor are these explicitly being mentioned in the medical definition of *secondary infertility*, referred to as the inability to bear a child after having had one or more earlier births. Thus, although the distinction between primary and secondary infertility allows us to comprehend the different dimensions of infertility within the reproductive life course of a woman, it underestimates the gradations and the complexity of infertility and fertility-related problems by excluding miscarriages and stillbirths from its conceptualization.

Yet pregnancy-loss is a recurrent phenomenon: overall, one in six pregnancies ends in a miscarriage. The rate of miscarriage is lowest for women aged twenty to twenty-four (10.6 percent) and increases steadily thereafter to 20.5 percent for women aged thirty-five to thirty-nine (Layne 1997: 308). In clinical terms, a miscarriage or spontaneous abortion is the loss of a pregnancy between conception and twenty-eight weeks of pregnancy. The involuntary loss of a pregnancy any time from twenty-eight weeks to term in which the fetus dies *in utero* or immediately following delivery is called a stillbirth (Akalin et al. 1997, Jones 2001). Both miscarriages and stillbirths reduce the chances of subsequently having a successful pregnancy outcome (London 2004).

Perhaps it was this ‘triviality’ of miscarriages that made even anthropologists inattentive to the phenomenon (cf. Cecil 1996); yet also induced abortions – *intended* pregnancy-losses – that were considered more ‘problematic’ have nevertheless often been discarded as a research topic since it was assumed that people would not be willing to talk about this taboo subject. Consequently, reproductive mishaps remained

in the margins of anthropological research for a long time. Yet this article shows that the topic of pregnancy-loss – voluntary or involuntary – indeed brings together many themes that are of anthropological interest and reveals the daily live uncertainties and strategies of women who are supposed to be mothers. These uncertainties and strategies are often two sides of the same coin and are part of a complex reproductive decision-making process – reason to examine both spontaneous and induced abortions at the same time. For, in contrast to the generally assumed oppositions between wanted and unwanted pregnancies<sup>3</sup> or unintended and intended losses<sup>4</sup> this article stresses the ambiguous dynamics of the prenatal period and the local variations and realizations of women's reproductive choices surrounding pregnancy and loss. Fieldwork was conducted among women in Cameroon, who often express the strong wish to have many children, but who simultaneously have to cope with pregnancy-losses or even consciously resort to abortion. This article will explore how these women think about this seemingly complex and even paradoxical situation and its consequences for their daily lives.

Given the insights of Africanists and new kinship studies, which focus on the cultural enterprise and socio-relational aspects of personhood, bodies and procreation in African cultures, I argue that the experiences and decisions of women with pregnancy-loss in Cameroon should be seen within their social contexts. I contend that pregnant women in Cameroon need to be considered as having 'social bodies' (Scheper-Hughes & Lock 1987), made up by and inherently interwoven with their social relationships in the fields of gender, marriage and kinship. This idea of a social body complements – or even criticizes – the notion of an autonomous individual that is implicit in demographical methods and in international biomedical health debates on reproductive choice. This bounded conception of the individual is based on Western assumptions; accordingly, it does not do justice to the relational, sociocentric aspects of daily life, especially in many African societies.<sup>5</sup> When people hold a relational perception of social reality in general and of the pregnant body in particular, this affects the ways in which they cope with, decide for and give meaning to loss during pregnancy.

Perceiving pregnant bodies as social bodies also places reproductive practices during pregnancy within its temporal and spatial dimensions. It shows how reproductive behaviour changes according to the social situation or position within a social network. It matters whether a woman is living among her own kin in her natal village or among her in-laws in another village; her decisions are dependent as well on the stage of the marriage process, the number of earlier (un)successful pregnancies and other socio-historical circumstances. Being constantly aware of the social situation at a particular time and place leads to a better understanding of the decisions that women make when they experience the social affair of pregnancy.

Therefore, after describing the research background and methodology of this study, I will draw on the social contexts that have to be taken into account in order to fully 'situate' the experiences of women with pregnancy-loss (cf. Greenhalgh 1995). These contexts, their complex interrelationships as well as their concretisation and manipulation in daily life experiences can best be captured through the narrative approach.<sup>6</sup> By listening to the narratives in which women give meaning to their personal experiences

of pregnancy-loss, relevant contexts, persons and situations that guide their reproductive behavior will come to the fore. As a case in point, the illness narrative of Jeanine, one of my informants, will form the basis for a more comprehensive discussion of aetiology notions, help-seeking processes and social consequences of pregnancy-loss. Through this detailed description, I firstly try to show the complex dialectic between agency and suffering in case of pregnancy-loss; secondly, I aim to give voice to those women, whose ambiguous and marginal experiences have too often been neglected.

## **Research background and methodology**

This paper is based on anthropological fieldwork in the village of Ndemba I in the rainforest area in the East of Cameroon from October 2004 until February 2005.<sup>7</sup> Living in the local dispensary in the centre of the village and being able to speak French with almost all the villagers, I easily made contact with the local population. Through the president of the women's corporation in the village, I met 10 women who experienced pregnancy-loss at least once in their lives. In the end, 15 informants aged between 15 and 50 intensively participated in this research. All informants, except for one young woman who finished her studies in a nearby city, resided in the village and made their living by working rather subsistently on their fields and trying to sell some of their products to neighbours or at the local market from time to time. Most of them had only had a few years of formal education. Eight of these women were living in the family of their husbands as a socially recognized married wife. Of these eight marriages, two were polygamous. The other seven informants lived in their own families; three of them considered themselves as married to the father of their children.

In order to build a relationship of trust between myself and these women, I made extensive use of the anthropological method of participant observation. Participant observation in this specific context mainly consisted of accompanying women to the field, caring for their children, assisting in the kitchen, eating together, visiting the market and church with them and spending free time together. However, not only did I partake in daily events, but I also participated in less mundane events, such as accompanying the women in their health-seeking processes – e.g., visiting 'traditional' and biomedical healers or studying auto-medication practices.

Next to informal conversations that took place during these events and daily life activities, multiple formal interviews were held with all 15 informants. These interviews centred upon several themes: marriage, kinship, values of children, pregnancies and ethno-embryology, aetiology of pregnancy-loss, different treatments of miscarriages, and motivations for abortion. All of the 98 interviews that I conducted – not only with the 15 informants, but also with 'traditional' healers and biomedical practitioners – have been transcribed verbatim. With regard to the aetiology of pregnancy-loss, use was made of the methods of free listing and pile sorting. In the free listing method, women were asked to name all the causes of pregnancy-loss that they could think of. Subsequently, all these terms were noted down on separate cards, which women were asked to sort in coherent piles. They could make as many piles as they

wished, putting those cards in the same pile that they considered most alike. These methods proved to be very effective; they demonstrated the complexity of local aetiology and proved insightful in relating aetiology to health-seeking behaviour.

Furthermore, one woman who experienced a miscarriage during my fieldwork period was asked to report her experiences, thoughts and feelings in a diary. These were intensively discussed afterwards and I followed her reproductive decision-making subsequent to the loss. For seven other women, life histories were recorded in order to comprehend and contextualize the lived experiences of pregnancy-loss. One of these narratives will be presented in this article. These stories showed the interrelation between the themes that were discussed separately in the foregoing interviews; they gave insight as to which aspects in daily life are important when it comes to reproductive mishaps; and lastly, they showed how reproductive behaviour is dynamic and changes over time.

By using the above mentioned anthropological methods, this research tried to overcome the shortcomings of the quantitative demographic research methodology – downplaying social relations within which reproductive decisions are enacted – which still underlies reproductive health debates. Although I conducted a demographical survey in the village in order to explore the local incidence of fertility-related problems<sup>8</sup>, this research focused mainly on the social contexts of individual reproductive decision-making as well as cultural constructions surrounding pregnancy, loss and childbirth.

## Exploring the field

This article is based on research conducted in the village of Ndemba I in the East province of Cameroon, as this is one of the regions with the highest fertility and infertility rates in the country. The *Enquête Démographique et de Santé* shows that the national fertility rate for Cameroon amounted to 5.0 children per woman in 2004, after having declined from 6.4 in 1978, to 5.8 in 1991 and to 5.2 in 1998. For the East province, however, the fertility rate remained high at an average of 6 children per woman in 2004. My survey data in the village of Ndemba I show an average of 4.7 children per woman.<sup>9</sup> Notwithstanding these high fertility rates, Cameroon has often been situated in the so-called ‘infertility belt’ of Africa. However, infertility rates over time show a strong decline; whereas in 1978 the incidence of primary infertility in the country had been found to be 12.1%, in 2004 only 3.6% of married women between 35 and 49 years old had never been pregnant. In Ndemba I, 7.1% of the 269 women who participated in my demographic survey declared to have never conceived.<sup>10</sup> These data show that fertility and infertility rates on both national and local levels are quite elevated. Besides, pregnancy-losses are frequent in Cameroon. In 2004, it is indicated that 18% of all women in Cameroon has experienced miscarriage at least once in her life. For the phenomena of stillbirths, the percentage is shown to be 4%. The data I gathered in Ndemba I show even higher percentages; as much as 39% of the 269 women has had the experience of pregnancy-loss at least once in her life.<sup>11</sup> In the *Enquête Démographique et de Santé* (2004) it is further stated that 5% of all women in Cameroon

would have aborted once. However, this percentage is surrounded by much uncertainty and infidelity, considering article 337 in the legislation of Cameroon, which condemns abortion in almost all cases. It is likely that a much higher incidence of abortion will prevail in local realities than official statistics indicate.

Although these statistics attempt to give insight in the prevalence of specific reproductive health problems on a larger scale, they do not deal with the personal *experiences* and *interpretations* of these phenomena. Those need to be studied intensively within their micro-level contexts. Therefore, in what follows, I will give a detailed description of the village life in Ndemba I as well as the fields of marriage, kinship and religion in which reproductive behaviour is enacted.

Ndemba I is inhabited almost entirely by people of the ethnic group of Bobilis, consisting of approximately 6000 people in this and neighbouring villages.<sup>12</sup> Situated within the rainforest area in the East of Cameroon, it is a rather large village in which a primary school, several churches and a health centre are located. Daily life is mainly characterized by subsistence economy with a fairly strong gender division of labour. Women have their own private fields on which they cultivate, *inter alia*, the food staples of corn, cassava and yams. Many of them earn a little money by selling some of their products on the weekly market of the village or on the bigger daily markets in B  labo, a nearby larger town. Men also go to markets to try and earn some money with their products –mostly their local wines *matango* and *mbang mbang*. Moreover, they hunt or own big cacao-plantations, on which their whole family can be found working. With the small amount of money that people earn, they can visit the three very small and scarcely provisioned shops (*boutiques*) in the village and the weekly market on Wednesdays where local people as well as outsiders try to sell their surplus food and some basic provisions. The segregation and complementarity of the sexes can not only be found in the economic realm, but also pervades the most intimate areas of daily life: marriage and kinship.

In Ndemba I, a marriage (*abal*) is concluded ‘traditionally’ through a series of exchanges between the (family of the) man and the family of the woman. These payments of the bride-price (*ivula*) constitute a process over time, consisting of various stages and various commodities, such as red wine, clothes, blankets, food, small animals and money. Ideally, when a man (and his family) wants to marry a particular girl or woman, he should go and ask the permission of this person and her family. When the proposal is agreed upon, the woman sets out to go and live with her new husband (*num*) and his relatives – often in another village, sometimes in another lineage in the same village. From this point onwards, a continuous process of gift-giving and service offering between both families is initiated and marriage is gradually concluded. The woman is now expected to bear children that will belong to the family of her husband. Next to marriages that are concluded traditionally through the payment of a bride-price, unions can also be asserted at the municipality or in the church. However, these are only rare instances and even the payment of the (parts of the) bride-price is nowadays often abbreviated or left out completely. Consequently, people sometimes refer to the living, eating and sleeping together of a man and a woman as a marriage, even though no bride-price has been paid and no reciprocal duties between both families



have been established (cf. Notermans 1999). Many marriages – especially those of young people – have become ‘trial marriages’ that are informal, fragile and flexible. They are easily dissolved as no reciprocal obligations between the two families have been exchanged. The same holds for the many informal sexual relationships (*ebonne*) that are maintained outside the conjugal setting, by men and women alike.<sup>13</sup> These relations easily shift according to the needs and wishes of both partners.

Kinship relations in Ndemba I are, like conjugal relationships, characterized by complexity and flexibility. The kinship idiom<sup>14</sup> of the Bobilis is mainly patrilineal: although the roles of both father and mother in procreation are acknowledged, children – containing blood of both parents – 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 anymore, opinions about this right differ. Moreover, in particular situations – such as when the man did not pay the bride-price, has an informal sexual relation with the woman, does not care for the pregnant women or worse, does not recognize paternity – children might be considered to belong to the family of the mother. From these many exceptions on the patrilineal rule, it becomes clear that matrilineal relations are integrated in the patrilinear framework. Indeed, it is in childbearing practices that many negotiations, conflicts and struggles between the family of the man and the family of the woman come to the forefront.

However, whether or not children are conceived within the conjugal setting – where women are *expected* to bear children –, most people will agree on their inherent values. ‘*L’enfant, c’est la richesse*’ (a child is a form of wealth) is an often heard proclamation when talking about reproduction. Children are highly valued because they continue the patrilineage (or, in some cases, the matrilineage) and prevent their parents from falling into oblivion when they die; they are an important work force in the daily life subsistence economy of the village; they maintain social relationships and solidify conjugal and kinship relations through fostering practices; and they offer their mothers social respect, status and security in a patriarchal, virilocal and polygynous environment where their existence is contested and easily replaced.

Considering these dynamics that are prevalent in the field, I will now focus on the particular situation of women whose pregnancy is terminated – voluntarily or involuntarily. Taking the story of Jeanine as a starting point, several local discourses and practices surrounding pregnancy-loss will be discussed, as well as their effects on the daily lives of women within the given socio-cultural contexts.

### **A narrative approach to women with pregnancy-loss: the story of Jeanine**

Jeanine is a woman, 32 years old, who lives with her husband, her 16-year old son Cereac and 14-year old daughter Lily in the centre of Ndemba I. She married when she was 15 years old and she bore her two children not long afterwards. But after she delivered her daughter Lily, she did not get pregnant again. She waited for a long time, but after two years she started to search for help. This is how she tells her story:

Many women in the village came to tell me that I must suffer from *vers de femme*, a sort of worm in the abdomen. They helped me to undergo traditional treatments. Especially my mother-in-law was helpful, since she knew how to treat this illness and she had already cured several other women in the village. She offered me herbal concoctions that I had to inject twice a day. However, it didn't work, so I had to look further. I started consulting traditional healers. They were so many, that I cannot remember their exact number anymore! I went to all the villages that you can find in this region. Many other women who suffered from similar problems gave me advice as to which healer to visit. And so I went and went and went.

One old woman in Bélabo prepared a pie with several medical herbs that I had to eat for three days. She promised that my problems would be gone afterwards. It turned out to be a lie. Another traditional healer told me that I had been cursed, but that the person who spoke out these words already died, so that I would never be able to be cured again. I did not lose faith but went to another healer in Ndoumba Olinga instead, who asked me to bring two eggs, a chicken, two bags of sugar, two bottles of milk and 2000 francs CFA [approximately 3 euros]. He made a powder and put it on my clothes, underwear and linen. I never found out why precisely he did this, but he promised it would dissolve all my problems. Afterwards, he predicted my future by analyzing the colour of a fire he had lit. As the colour was deeply red, he told me there are still a lot of children in my uterus. Within one month, he promised, I would get pregnant. But it did not happen. In Adiah, an old man gave me different kinds of fruits that would clean my belly. According to him, I could not get pregnant because there was too much dirt inside my body. This treatment made me very sick and I spent a week in bed. In Bertoua, I visited a *marabout* who told me that in the end I would deliver eight children. He made some incisions in my skin and wrapped some medicinal leaves in them. These leaves had been mixed with crushed bones of the animals that my husband chased that day. His explanation was that witches were being jealous of the hunting successes of my husband and would therefore cause my fertility problems. Oh, I heard so many explanations! All of them told me I still have a lot of babies in my belly, but why don't I see them?

Three years ago my mother-in-law told me that she knew an old woman in Bélabo who treated many diseases. Well, this woman told me that there was an illness that prevented me from becoming pregnant again. She could treat it, she said, but a complete treatment would involve both me and my husband. But my husband was not willing to participate. As to him, he had a lot of girlfriends and even two extra-marital children, so he did not bother too much about me. He said all these treatments had already cost him too much money and that he didn't have time to go to this old woman. This woman predicted: if your husband will not come, you will get pregnant, but miscarry. And indeed, after six years of searching for help, I got pregnant again. It lasted three months. I miscarried. We went to the hospital, but it was already too late. The doctor gave me some injections to clean the uterus. Everybody told me that I should not have carried that heavy bucket with nuts on my head. That was what had caused my miscarriage. But deep inside, I only think of the words of this wise old woman. I knew she had turned out to be right.

Ever since, I consulted a lot of healers and *marabouts*. They all tell me different stories and earn a lot of money with it. But I keep on hoping, visiting them, paying a



lot of money, and getting disappointed time and again. I even went to the hospital. But here they say they cannot cure me without also treating my husband, who pertinently refuses to participate. He says it costs too much money. Fortunately, I am a member of the women's corporation in the village, where we can save some money. Thus, I keep on searching. Because, in a short while, Lily will marry and leave my household. I will remain all alone. I am lucky to have my brothers and sisters, who regularly send me their children. Every time my sister weans her baby, the child comes to live with me for some years. Then, my house is filled with children.

### Aetiology of pregnancy-loss

Pregnancy-loss (*abum iaso*, literally: 'the pregnancy leaves') is a phenomenon that thwarts the patriarchal ideal of bearing many children. In general, every pregnancy is welcomed as a happy event that needs to be taken good care of in order to bring it to term successfully – e.g., through several prohibitions and taboos that intend to protect the pregnant woman and the foetus from harm. When a pregnancy then fails – an event that is often not anticipated nor wished for – explanations are sought for almost immediately. These explanations, as we will see, determine which treatments will be consulted after the miscarriage, as well as the way the misfortune is coped with by the woman herself and her surroundings. In this study, 76 causes have been found, which women themselves often grouped in distinct 'larger' classifications. Although I do not pretend to give an all-encompassing, coherent account of what turned out to be often contradicting and varying descriptions of informants – a critique on the representation of ethno-medical 'systems' that has also been uttered by Pool (1994) – in the following, I will present the ideas that women in Ndemba I related to me with regard to the aetiology of pregnancy-loss.

Firstly, women indicate that miscarriages and stillbirths are often the result of intensive bodily movements during pregnancy. The specific causes that they think of are mostly related to their heavy working conditions and multiple tasks: washing clothes, gathering wood, working on the fields, walking far distances, carrying heavy weights on the head or falling with these weighty bundles when they walk back from their fields to the village. Although local discourse narrates that pregnant women should avoid these heavy tasks – as we see in Jeanine's story where she is reprimanded for carrying a heavy bucket on her head – my informants often told me that they have no choice as to whether or not to fulfil their daily duties; nobody else would do it for them.

Second, numerous diseases (*mekong*) are considered to be a cause of ending the pregnancy. Not only does this include biomedically recognized diseases such as AIDS, sexually transmitted diseases (*mekong bunka ne panum*), malaria (*avo*), jaundice (*zom*) or dysentery (*melaab*) – irrespective of whether or not they are indeed considered to be a threat to pregnancy in biomedicine – but also folk diseases are abundantly related. One of them concerns a type of worm (*song munku*) located in the belly of some women, which 'eats' all the blood destined to form a foetus after conception.

This is the worm that Jeanine talks about in the beginning of her story. Another folk disease is called 'warm water' (*medi medonga*) that would burn the developing fetus in the uterus – leading to a stillbirth. Further, folk notions and biomedical terms are often interestingly combined or complemented with each other, as in conceptualizations of jaundice as a moving ball of blood in the belly or in expressions of sexual potency in terms of biomedical blood groups. Thus, although ethno-medical and spiritual explanations of diseases and physical problems are not officially recognized in biomedicine, these local aetiologies do integrate biomedical ideas and notions in their indigenous health concepts.

Related to these indigenous health concepts is another locally narrated situation that is recognized as being fatal to reproductive success: namely, when the blood of the man and that of the woman are not compatible (*'les sangs ne se croisent pas'*). At the moment of conception, the sperm (blood) of the man and the blood of the woman need to be of the same type. Blood has several symbolic dimensions in this community: it reflects the character and the internal state of a person, as well as his or her power-related position in the community. Consequently, the blood of the man is considered to be inherently stronger than that of a woman. Still, complementarity is in some way needed to be able to develop a healthy child – as daily life in the village is also based on complementary of male and female tasks. When the blood of one person is much stronger than that of the other, this combination will always lead to loss during pregnancy. These symbolic dimensions of blood are concretized in 'blood groups' A, B, and C – another instance of incorporation of biomedical language in local conceptions of reproductive health.

Another concern that women have in order to bring their pregnancy to term is the adherence to traditions (*tum*). As was mentioned above, women's behaviour is subjected to many taboos and restrictions (*ikil*) during pregnancy. These apply both to food intake and to daily practices. Accordingly, when a woman fails to live up to these traditions – knowingly or unknowingly – she will risk losing her foetus. The precise causal relation between the violation of traditions and resulting pregnancy-loss is often not specified by women – only a few of them referring to the wrath of God (*Zambe*) or ancestors.

Contestation also prevails when it comes to indigenous medicines (*bile*), which form another threat to pregnancies. Women in Ndemba I know many herbs, leaves and barks that are not only used to heal regular illnesses, but also to ward off spiritual attacks, prevent other kinds of misfortunes, or, on the contrary, to achieve certain goals effectively; consequently, they told me, these could be used to terminate a pregnancy as well. Here, a distinction should be made between women using these natural products themselves in order to consciously abort their pregnancies and others applying them secretly when aiming at the destruction of fertility of others – e.g., co-wives. The ambivalence of these medicines has been described by Pool (1994) for the Wimbun people in the West of Cameroon as well. Due to the multifarious functions of these medicines, people often attach mystical powers to them. Indeed, people in Ndemba I had conflicting opinions on whether or not someone needed to be a witch him- or herself in order to successfully use *bile*.

This brings to light the many stories of witchcraft (*mb l*) that prevail when a pregnancy is terminated unexpectedly. An innocent woman can be attacked by a witch that despises or envies her – as in the case when an infertile witch causes pregnancy-loss in a co-wife with many healthy children. As these witchcraft beliefs are pervading all aspects of life, witchcraft accusations abound when a woman loses her foetus unexpectedly. However, at the same time this woman runs the risk of being accused of possessing *mbal* herself, notably in the form of *ivu*, a little creature in the belly of women. The most prevalent story recounts how witches meet during nightly gatherings where they eat (*adjiki*) people and blood, preferably close relatives. Every witch has to offer one of his or her relatives in turn. When not fulfilling this reciprocal duty, the witch risks being eaten by the other witches. Thus, if a witch happens to be pregnant, she can decide to kill her foetus and offer it to the other witches. Another way of losing a baby in the world of witchcraft is during the nightly battles, mostly inspired by jealousy and power differences, where witches aim at the destruction of other witches and/or their foetuses. Finally, some stories relate how the little creature of *ivu* satisfies its strong desire for blood by starting to eat the foetus next to him in the uterus of a pregnant witch. Consequently, a woman who miscarries is always suspected of being a witch herself. Especially her husband and his family, who eagerly await the moment a woman will bear some children for the lineage, are not hesitant to accuse her of ‘eating’ her children in those cases where she has not been bearing any live children for too long a time<sup>15</sup> – sometimes even rejecting or chasing the woman from the family.

However variable the many witchcraft stories are, they all show how reproductive success depends on relational harmony and equality. Whenever pregnant women are surrounded by jealousy, envy or conflict, there is a possibility that their pregnancy could be in danger. The fact that *ivu* aims at destruction within the field of kinship – a field that is by its very definition relational – shows that trust, harmony and affection are not even self-evident in the most intimate spheres of social life but should be constantly accomplished and enacted (cf. Geschiere 2003). It is here that the idea of pregnant bodies as social bodies comes to the foreground; pregnancies in Cameroon – as elsewhere – are not individual and strictly personal, but instead are pervaded by social relations and the dynamics inherent in them.

Another ‘mystical’ force that forms a danger to pregnancy is malediction (*bidokh*), mostly coming from the mother or other near relatives of the woman. People that have put much effort in the education of the woman during her youth can curse their ‘daughter’ in case of extreme conflict or disobey. Here, only the word or the sentence suffices to call misfortune onto the woman – e.g., ‘if I was the one who suffered for you, then you won’t bear any live children in this marriage’. It is only the person who uttered these words who can undo its effects in a specific ritual of reconciliation. As Jeanine recounted above, death of this person transforms the curse into a life-long condemnation. Again, as in the case of witchcraft, we see how the fulfilment of pregnancy depends on relational harmony and the goodwill of others.

But reproductive success also depends on the goodwill of the pregnant woman herself. For last, but certainly not least, are those instances where she consciously resorts to abortion (*asong abum*); a decision that is dependent on specific situations

and motivations in the course of a woman's life. Although abortion is a criminal offence in Cameroon punishable under section 337 of the Penal Code, many informants asserted that several circumstances can make an expecting woman decide to end her pregnancy. Not only did I encounter the many cited reasons of being too young, fear of parents, the desire to finish school, having other aspirations at the moment, instability of premarital informal sexual relationships, difficult economic situations or, for married and older women, extramarital pregnancies, health concerns or the spacing of births; reasons that can be found in other recent studies as well (Adepoju 1999, Calvès 2002, CEPED 2000, Guttmacher Institute 2003, Henshaw *et al.* 1999, Koster 2003). I also came across an interesting aspect, related to the patrilineal kinship situation and the related 'patriarchal ideology' of women having to bear many children. Within a marriage that a woman considers disappointing, difficult, or poor, because her husband or his family do not meet her expectations, not adhering to this patriarchal ideal can serve as a means of revenge towards them. Abortion in these cases forms a practical strategy that women use not in spite of, but rather *because of* the existing (male) ideal of having many children. A woman can consciously choose whether to adhere to this patrilineal norm and satisfy her husband and family-in-law, or to actively control and restrict her own reproductive capacity in order to 'punish' them. However, it is only women who already possess a certain amount of 'capital' (Bourdieu 1977, 1989) – be it a powerful position within personal networks, a socially appreciated number of children, the financial rewards of extramarital affairs or alternative ways of caring for children – who will be able to punish their in-laws without punishing themselves. Thus, the contexts and personal situations and aspirations of a pregnant woman determine whether a pregnancy is wanted or not, and consequently, the outcome of the pregnancy. During the course of life of women in Cameroon, it is situationally dependent whether the ideal of many offspring is adhered to or rejected.

Analysis of this complex and elaborate set of dynamics leading to pregnancy-loss reveals the centrality of the question of culpability. Both naturalistic and personalistic causes of pregnancy-loss were identified by my informants. Naturalistic explanations do not aim at appointing an intervening agent that would have caused the misfortune, whereas personalistic interpretations construe illness as intentionally inflicted upon the sufferer by some sort of agent – be it God, ancestors, witches or co-wives.<sup>16</sup> When it comes to pregnancy-loss, this dualistic distinction is complicated by the fact that it could also have been the woman *herself* who enacted this loss. The various degrees to which the guilt of the woman herself is implicated in the diverse causes of pregnancy-loss lead to a flexible and strategic idiom that can be differently enhanced by different actors at different moments. A woman who experiences pregnancy-loss will often strategically denominate a possible causal factor that turns the attention and blame to something negligible or to other people rather than to herself – in order to not exacerbate her precarious social position and other related negative consequences that follow the event. In this case, to portray oneself as a passive sufferer turns out to be an active strategy not to make oneself suspect and to divert attention from the possible agentic side of the aetiology of pregnancy-loss. Thus, suffering and agency are

dialectically implicated rather than mutually exclusive. Spontaneous loss and induced abortions become intertwined in women's discourses. Further, the fact that different explanations imply different degrees of culpability offers the possibility to fluidly change explanations and change treatments – a topic that I will turn to in the following paragraph.

### **Treatment of pregnancy-loss**

The choice of medical help that is being sought after pregnancy-loss is heavily influenced by the ideas that people have concerning the causes of the specific loss. As we have seen, in the aetiology of pregnancy-loss different categories of causations can be discerned; accordingly, women will seek for treatment that they consider most capable of curing the anticipated cause of the loss. The variety of treatments in the village of Ndemba I and its surroundings can be classified in three health sectors: the popular sector, the folk sector and the professional sector (Helman 1994) – all of which are consulted in the case of pregnancy-loss. The popular sector entails informal help coming from the close social relations of the woman in question. With respect to the specific case of pregnancy-loss, this includes psychological and emotional comfort from kin, neighbours and friends, but also the sharing of treatment-related knowledge. People will give advice as to which healer to consult or in case they possess knowledge of any treatment of pregnancy-loss themselves, they will gather the needed resources and apply their knowledge directly – a form of selfmedication locally known as '*à l'indigène*' and, due to a lack of financial resources, very widespread in the village. Most people – especially the older generations – do have some basic knowledge about healing powers of natural plants and some of them specialize in the treatment of particular illnesses. Consequently, the popular sector entails this whole informal social network of people possessing appropriate medical knowledge and other forms of resources for support.

Contrarily, the folk sector entails the same kind of knowledge, but in a more elaborate and more organized form, including all forms of help offered by, among others, traditional healers, *marabouts* and herbalists. In case of pregnancy-loss, local midwives can be added to this group as well. Thus, the folk sector is characterized by variation in healers, treatments, specialties and conceptions of health and illness. What unites all these different healers, is the fact that their treatments are based on 'natural' products such as leaves, barks and herbs. Furthermore, they share a holistic approach that not only takes into account physical and emotional symptoms but many other (relational) aspects of the daily social life and the worldview of the patient as well (Helman 1994: 68). Consequently, in case witchcraft, malediction or violation of taboos are thought to be the cause of reproductive misfortunes, these healers in the folk sector will be consulted – often at a considerable price, as is shown in the story of Jeanine.

Finally, the third health sector is formed by the professional sector of biomedicine, consisting of hospitals and other biomedical health centres. Only a few women in

this study sought recourse to the locally situated public health centre in Ndemba I. When they did so, it was mostly to cure blood loss, foetal wastage, physical complaints or biomedically defined diseases. The popular and folk sectors are far more often consulted, not only because they do not demand the large amounts of money that have to be paid at the hospital, but also because these treatments are based on an aetiology of pregnancy-loss that much more resembles the ideas of women and their families about the causes of miscarriages and stillbirths. As Helman (1994: 68) indicates: 'Most folk healers share the basic cultural values, and world view, of the community in which they live, including beliefs about the origin, significance and treatment of ill-health'. Nevertheless – as has been discussed with regard to the aetiology as well – these different sectors often intermingle and people have strategically and pragmatically received, adapted or rejected biomedical aspects within their local health care traditions and perceptions, leading to many combinations, specialisations and contestations.<sup>17</sup>

Consequently, complexity and flexibility characterize not only the aetiology of pregnancy-loss, but also the help-seeking process following the event. Due to the plural medical system in Cameroon, many possibilities and solutions are flexibly and strategically explored and utilised. Different medical practitioners are being consulted, often interchangeably and at the same time. Traditional and biomedical treatments are being combined and are considered complementary rather than mutually exclusive. This variability in both the discourse on loss and the treatments following it, on the one hand strengthens women who are in the precarious situation of having experienced pregnancy-loss. It offers them the possibility of strategically using the rhetoric and changing their trajectories when certain options do not seem to work out – providing them with an excuse for delayed childbearing at the same time. To borrow a phrase from Foucault, the medical pluralism offers women 'a multiplicity of discursive elements' (Foucault in Howarth 2000) surrounding reproductive loss that can come into play in various strategies. On the other hand it also illustrates the insecurity of their situation. One only has to recall the desperateness of Jeanine after having explored many options and being left empty-handed – both financially and socially. The help-seeking process involves a lot of insecurity and ambiguity. Again pragmatism and ambivalence are two sides of the same coin; women are sufferers and agents at the same time (cf. Lock & Kaufert 1998).

A few safety-nets do exist that help women in reducing this insecurity. People that might assist a woman in the search for treatment – and therefore fertility and security – after pregnancy-loss, include not only her husband and in-laws, but also her own kin and women's associations in the village. I heard many stories of family members who had tried to collect some money among family members or fellow-villagers in order to help their daughter (in-law) or sister (in-law) continue her treatment seeking process. Further, this financial assistance can also be found in the women's corporations – some of them related to the Catholic church – that are present in the village of Ndemba I. These groups are collectively saving or donating money in case misfortune befalls one of their members. In all of these cases, it becomes clear that social relations of reciprocity are crucial in order to successfully pursue the search for fertility



and security. A woman's position within a certain social network will influence the degree and nature of help she will receive. Therefore, let us turn now to the way this social position of women is altered when they experience pregnancy-loss – a crucial issue when trying to fully comprehend their experiences, options and strategies.

### **Social implications of pregnancy-loss**

When a woman experiences pregnancy-loss, she will be comforted emotionally and assisted physically by closely related (mostly female) others. Most often, her mother or mother-in-law will come and wash her, give her massages and prepare some food. Other people in the household will take over the domestic chores for some days in order to allow the woman to physically recover. Neighbours, friends and family members will come and express their grief and sorrow – as happens in all cases of death. However, the burial and mourning rituals already show the ambivalence of the situation. From the moment the human forms of the foetus are clearly visible – people often mention from 3 months pregnancy onwards – the foetus will be buried rather than thrown away in the forest or in the latrine, as happens with the expelled blood of very early miscarriages. However, the burial does not entail the long and intense process that is normally encountered when a 'real person' has died. The foetus is not buried in a coffin, but rather hastily wrapped up and buried in some clothes or leaves immediately after the miscarriage or stillbirth, without any people attending. On top of the grave, some leaves are planted – connecting the underground world with the 'real' world, symbolizing the return of the foetus into this world at a later stage and anticipating that the mother will soon be pregnant again. This aspect is also stressed in mourning rituals: people who come over to comfort the woman urge her not to weep anymore and to go on with her life, so that she might soon become pregnant again and bear another child – hopefully alive and healthy. They remind her of the widespread belief that a too extended period of inactivity and sorrow would result in the woman remaining barren for the rest of her life. Sexual intercourse with her husband or the author of her lost pregnancy is strongly encouraged for the same reason. This coolness and rationality of visitors stand in sharp contrast to the animated and emotionally charged burial ceremonies that disquiet the village when one of its members has passed away.

As time passes by, the compassion that people expressed right after the event is more and more replaced by this notion of forgetting what happened and trying to have another baby. Explanations for the event, as those discussed in the aetiology above, will be sought in order to cure the problem that is at hand and thus remove every possible obstacle to a following pregnancy. The degree to which women, their husbands and family members are inclined to actively tackle the problem depends on the social position and the personal situation of the woman involved. Especially her reproductive status within the family of the husband is an important aspect that influences the amount of support she can expect from her in-laws. For example, when she is a newly married wife who has not delivered any live children yet, her husband and his family

will be rather impatient to see a new pregnancy. This woman still has to 'prove' her fertility and risks being repudiated when she remains childless after a time. Thus, the in-laws will either do their utmost best to help this woman restoring her fertility or they will send her back to her family right away when they think she is not worth the investment. Especially when bride price payments have not yet been initiated – and very often these do not start before the woman bears her first live child – repudiation does not entail too much difficulties. Other, less radical, options include the widespread practices of polygyny or fosterage: the husband might decide to take a second wife who can 'give' him the children he is waiting for, family members of the husband or woman might offer a foster child to the couple or the woman herself might claim the children of her sisters or brothers. In this way, the woman can be offered a less precarious situation within an environment where her status depends on the number of children she bears. Accordingly, when a married woman has already given birth to healthy children earlier in life, one particular reproductive mishap will more easily be tolerated by her in-laws – who will nevertheless expect her to bring another pregnancy to term in the near future. However, when pregnancy-losses constantly follow one after the other – even in the event of already having borne several healthy children – suspicion will rise and the woman risks being accused of 'eating' her foetuses in the world of *mbəl*.

The different accounts of compassion on the one hand and suspicion on the other reveals the ambivalent status that women have when they do succeed in conceiving, but not in bringing pregnancies to term. Informants stress that their situation is better than those of infertile women, as they have been able to at least 'prove' their fertility; however, remaining childless in the end makes their condition comparable to those of infertile women, who are not considered 'real' women and feel lonely, rejected and inferior. As the women in this study already showed their fertility in some respect, people generally allow them some time to adjust their marginal status and to eventually prove their 'worth' at a later stage – for instance, by actively using the idiom of the aetiology in order to turn attention to other causes than themselves, by desperately searching for help, by trying to get pregnant as soon as possible or to resort to fosterage practices as an alternative strategy of motherhood. Despite the room and time for manoeuvring in this marginal situation, feelings of ambiguity and insecurity prevail.

### **Conclusion: ambiguous ambitions and marginal motherhood**

Three main conclusions can be derived from the above. Firstly, this study showed the discrepancy between a macro-level patriarchal discourse, which prescribes women to bear many children, and micro-level reality for many of these women – a discrepancy that places them in an ambiguous situation. Due to the mostly collectively adhered to ideal of a large offspring, almost all people in Ndemba I express the desire for many children and express their sorrow and grief when pregnancy fails. A woman who miscarries can not live up to the ideal of respected motherhood at a specific moment, but she is not totally infertile either; as a consequence, a woman who loses her

foetus (also a highly ambiguous creature), can not be included in one of the two fertility-based categories, thereby being defined as marginal, ambiguous and anomalous (Douglas 1966: 37). This ambiguity is most of all at play when a woman did not bear any live children yet, when she just arrived in the family of her husband and will have to 'prove' her fertility. Deprived of the social and symbolic capital (Bourdieu 1977, 1989) that living children could offer her, her situation is precarious. Ambiguity is at play in several other ways as well. In some cases, being pregnant *per se* can already lead to an ambiguous experience when it is not sure if the child is wanted. Both pregnancy and loss can lead to *internal* ambiguous feelings. Furthermore, the fact that it could have been the woman herself who has caused the termination of the pregnancy makes the phenomenon ambiguous for *outsiders*, especially her husband and in-laws, who are well aware of the possible existence of those 'secret strategies' (Koster 2003). Witchcraft accusations that sometimes follow repeated pregnancy-losses depict the woman as even more ambiguous. Finally, for women that resort to abortion themselves, the discrepancy between their own motives and aspirations at this moment and the expectations and condemnations of (Christian) people and Cameroonian law around them, make them experience an ambiguous situation. Illegality and immorality lead to marginality and ambiguity.

Secondly, this study showed that women who experience spontaneous pregnancy-loss in Cameroon cannot simply be depicted as stigmatized victims, contrary to what is suggested in the literature on negative consequences of fertility-related problems for women in Africa (Adepoju 1999, Boerma & Mgalla 2001, Erny 1988, Eschlimann 1982). Rather than perceiving women as sufferers of male dominance and patriarchal norms, this study took as a starting point the argument of Foucault (cited in Regis 2003: 45) that power is diffuse and works through a great variety of practices – practices that in case of pregnancy-loss interestingly combine aspects of suffering and agency. Despite (or maybe precisely *because of*) their marginal and ambiguous status, women who unwillingly experience loss during pregnancy are rather strategic actors, not only in the realm of accusations and modes of explanations for the loss, but also in their treatment-seeking behaviour. The informants in this study were constantly making conscious decisions to improve their own situation within the given social structures and web of relationships that are so much emphasized by Africanist scholars like Piot (1999). Further, the agency of these women is most clearly exemplified in the cases in which they resort to abortion; a decision that is dependent on specific situations and motivations during their life-courses. Indeed, it is especially in the 'female' realm of reproduction that women make strategic choices: childbearing as well as abortions are often consciously enacted. And it is often in the margins of motherhood that these ambiguous ambitions – those that challenge patriarchal ideals – come to the fore.

Lastly, in order to fully comprehend which strategic options are available to women and which are not, the micro-situation of social relationships should be taken into account. It is not only the macro-ideal of bearing many children, but also, and more pertinently, the way this ideal is enacted and given meaning to within the micro social environment, that influences the way pregnancy-loss affects the lives of women. Loss

in this context does not so much involve individual bodies, but should rather be studied within the social web of relationships that women have – thus considering their bodies as being inherently ‘social’ and relational (cf. Scheper-Hughes & Lock 1987). Social relationships and the position of women within these relational webs influence the ideas on the specific causation of pregnancy-loss, as well as the way women are able to find practical, emotional, financial and medical help. Several forms of help that were discussed in this paper show how the negative social consequences of not adhering to the ideal mother-image can in fact be countered through these social networks. Thus, social circumstances on a micro-level can to a certain extent undo the effects of macro-level discourses.

By taking the social contexts of women with pregnancy-loss into account, this study allows for a space between ‘active’ and ‘passive’ concepts of reproductive decision-making; fertility is not considered the result of rational cost-benefit analyses nor of passive adherence to norms. Rather, I argue that reproductive practice flows from a dialectical relation between acting people and the setting in which they do this – emphasizing the interconnection between agency and structure. It is only by taking the dynamics of these social worlds into account that we can come to understand the complex dialectic position of sufferer and agent of mothers in the margins.

## Notes

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- 1 Negative international preoccupation with population started after World War II, when nationalist movements in colonized states struggling for independence, could flourish because of population growth in these areas. From the end of the 1960s onwards however, environmental concerns inspired the population debate. A Malthusian style of thinking – concerned with the negative effects of ‘overpopulation’ on the natural environment – was present in Ehrlich’s *The Population Bomb* (1968), the Brundtland report (1987), and *The Population Explosion* by Ehrlich and Ehrlich (1990), leading to measures of population control. With changes in the international population debates and structural adjustment policy, unrestricted population growth came to be seen as an impediment to socio-economic development as well. Policies were developed that incorporated growth-control into the overall development scheme (Brand 2001, Buse *et al.* 2002).
- 2 For literature on high fertility levels in Africa, see for example Baerends (1994), Calvès & Meekers (1997), Eschlimann (1982), Nana-Fabu (2001), and Wakam (1992). Studies on

experiences of infertility in Africa include, among others, Becker (1994), Boerma & Mgalla (2001), and Sandelowski (1990).

- 3 Johnson-Hanks (2006) shows the deficiency and fluidity of these terms as she used them in her survey among Beti women in Cameroon, which led to very little negative responses – indicating that over time feelings and meanings surrounding a pregnancy can change (e.g., from unwanted to accepted and wanted). Therefore, instead of asking people in retrospect whether a certain pregnancy was wanted or unwanted, she proposes to ask them whether it was *foreseen* or *unforeseen*.
- 4 In the daily life experiences and narratives of the Cameroonian women I encountered, spontaneous and induced loss lie very close to each other. Not only are the medical treatments and consequences the same for women undergoing the loss, but the distinction becomes also blurred for outsiders: abortions can be presented as miscarriages; miscarriages can be suspected to be abortions; a woman might fail to successfully abort her pregnancy in the first trimester, but finally lose her fetus towards the end of the pregnancy, not knowing whether this is a direct result of her intervention or not; or, at the other extreme, miscarriages can be invented to hide infertility.
- 5 Although this view of an Western autonomous individual may be questioned (as has been done by for instance Carsten (2004) who shows the relational notions of personhood and relatedness in Western cultures) and the rigid dichotomy between individualistic and sociocentric in terms of Western and non-Western may be largely oversimplified, my main argument here is that the idea of a bounded autonomous individual certainly does not apply to persons in non-Western cultures. Thus, in these relational societies studying the social body is more revealing than in individualistic societies.
- 6 The advantages of the narrative approach and more specifically the anthropological life history, have been described by, among others, Kleinman (1988), Gijssels, Mgalla & Wambura (2001) and Rosaldo (1989). Not only are narratives a format for the informant to freely discuss ideas and experiences, but they also offer the researcher the possibility to contextualise data and to gain complex insights in contradicting views and ‘ever-changing, multifaceted social realities’ (Rosaldo, 1989: 128).
- 7 This fieldwork was the last part of my study Cultural Anthropology at the Radboud University in Nijmegen, the Netherlands. The MA-thesis that I wrote under the supervision of dr. Catrien Notermans is titled: *Paradoxaal door kinderideaal: Marginaliteit en strategische activiteit van vrouwen met zwangerschapsverlies in Kameroen* (2005) [Free English translation: *Paradoxal as a consequence of the ideal of bearing many children: marginality and strategic activity of women with pregnancy-loss in Cameroon*].
- 8 In this survey, I visited all households of Ndemba I and selected all married women and all women who were not (yet) married, but who had experienced at least one pregnancy in their lives. In total, 269 women reported their age, the number of pregnancies they had had, the number of pregnancy-losses, the number of live births and the number of children still living at the moment of the survey.
- 9 The difference between the official fertility rate of 6 children per woman and the 4.7 children that women in Ndemba I on average reported to have, can be explained by the fact that fertility rates hypothetically calculate the number of children that women will have *at the end of their reproductive careers*. A real population as in Ndemba I, however, consists of women of all ages, including the ones that just started their reproductive life courses. The average number of children in a real population is therefore always lower than the hypothetically calculated fertility rate.

- 10 Here again, the difference between the official infertility rate and the number of married women in Ndemba I who did not experience any pregnancy until the moment of the survey, can be explained by taking the ages of the women in account. Official infertility rates are based on declarations of women aged thirty-five to thirty-nine, thus *at the end of their reproductive careers*. My survey data however, are based on declarations of women of all ages, including the ones who just attained their reproductive ages and/or just started conjugal lives and who will most likely experience one or more pregnancies in the future. The group of women who declared never to have experienced any pregnancy until the moment of the survey thus comprises both fertile and infertile women.
- 11 Most likely, this percentage also includes false declarations of infertile women who might want to 'hide' their infertility and of women who consciously induced abortions but might want to present the pregnancy-loss as 'spontaneous'.
- 12 A census conducted in 2005 identified 2343 inhabitants in the village of Ndemba I. The local language that members of this ethnic group speak is Bobilis or Gbigbil (part of the Yaounde-Fang group of languages, classification A73b; Guthrie 1953: 40). In this paper, local terms are denoted in French or in Bobilis interchangeably.
- 13 All men are believed to be adulterous and their behaviour is tacitly accepted and assumed natural; for women there are similar possibilities and freedoms due to the flexibility of the marriage process, but their behaviour should not become known – they can do it but should never speak about it or make it public (the most extreme case of which would be an extra-marital pregnancy).
- 14 I prefer to speak of kinship as an 'idiom' rather than a 'system', because it stresses the negotiability and situationality of kinship norms and the way they are strategically used. A kinship idiom offers certain norms and categories, but these are liable to different interpretations and applications to very divergent situations and persons (cf. Geschiere 1982). This makes kinship more a social phenomenon and cultural enterprise of relatedness rather than a biological affair of mere procreation – an argument that is prevalent in new kinship studies in anthropology, reacting against the biological essentialism of former studies on the subject (see for instance Carsten 2004, Holy 1999, Strathern 1995, and Franklin & Mc Kinnon 2000).
- 15 When people are asked what is considered 'too long a time', they often mention two or three years without bearing children. However, the life history of one of my informants showed that the family of her husband rejected her after less than one year of remaining without children. Her in-laws organized family meetings in which they discussed her case and decided that they could not accept her as the wife of their son.
- 16 See the work of Coronado (2005), Davies (2006), Janzen (1989), Monteillet (2005), Pool (1994), and Ventevogel (1996).
- 27 See for instance Allen (2002), Brand (2001), Coronado (2005), Davies (2006), Gottlieb (2004), Gijssels et al. (2001), Helman (1994), Hollenberg (2006), Feldman-Savelsberg (1999), Lock & Kaufert (1998), Maynard (2004), Pool (1994), and Sugishita (2006).



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