"Spoiling the Womb": Definitions, Aetiologies and Responses to Infertility in North West Province, Cameroon

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ABSTRACT

Only one generation ago, the Cameroonian national population policy was pro-natalist, with great attention paid to the problem of sterility. Now, family planning is promoted nationwide to reduce population growth, and infertility is not addressed by public health policy or services. In contrast to the biomedical definition used by planners, at the local level infertility is defined as the inability to have a child when desired, and it has many causes including contraception, abortion and witchcraft. The young, less educated women especially are unlikely to use contraception as long as they feel susceptible to infertility, since their economic, social and psychological status hinge on their ability to have children. Drawing from epidemiological literature and qualitative data gathered in a market town in North West Province, I argue that a more balanced approach to reproductive health, one that recognises the importance of infertility, is critical for women's health and well-being. (Afr J Reprod Health 2002; 6[1]: 84–94)

RÉSUMÉ

"L'Endommagement de l'Utérus": Définitions, Etiologies et Réponse à la Sterilité dans la Province du Nord-Ouest, Cameroun. Il y à seulement une génération de cela, la politique nationale camerounaise de la population était pro-nataliste et mettait beaucoup d'accent sur le problème de la stérilité. À l'heure actuelle, on promouvait la planification familiale partout dans le pays afin de réduire la croissance démographique et la politique de la santé publique ainsi que les services publics ne s'occupent pas de la stérilité. Contrairement à la définition biomédicale dont se servent les planificateurs au niveau local, on définit la stérilité comme l'incapacité d'avoir un enfant quand on le veut pour des raisons différentes y compris la contraception, l'avortement et la sorcellerie. Les jeunes femmes, surtout celles qui ne sont pas bien instruites ont moins la possibilité de se servir de la contraception tant qu'elles se sentent susceptibles à la stérilité puisque leur statut économique, social et psychologique dépend de leur capacité d'avoir des enfants. En me basant sur la littérature épidémiologique et sur les données qualitatives recueillies dans une ville commerciale dans la Province du Nord-Ouest, j'avance l'argument qu'une approche plus équilibrée de la santé reproductive, celle qui reconnaît l'importance de la stérilité, est cruciale pour la santé et le bien-être de la femme. (Rev Afr Santé Reprod 2002; 6[1]: 84–94)

KEY WORDS: Women's infertility, family planning, population policy, Cameroon

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Introduction

One of the ironies of the demographic and epidemiological transitions in sub-Saharan Africa is that as population growth has increased the rates of infertility have also increased, due to higher rates of sexually transmitted infections (STIs) and earlier age at initiation of sex. Thus, while the focus at the national policy level has been population control through family planning programs, a major concern at the individual and community levels is the fear of not being able to have a baby when desired. The data for this article, gathered in Bali Nyonga, North West Province, Cameroon 1994-95, offers an insight into this paradox as it occurs at the local level, in conditions of social flux, economic stagnation and political instability common to market towns in the region.

With education and entrepreneurial opportunities now open to younger unmarried women, the need for contraception has never been greater. On the other hand, having children to prove fertility, to mark adult status, and to create ties of obligation with men are reasons that remain critical for women regardless of age, marital status, educational level or occupation. In this period of economic decline and social conservatism, women's economic self-reliance is still an unrealistic dream, and delaying marriage and motherhood for any reason leaves women vulnerable economically, socially and morally. The fear and experience of infertility, I argue, is a driving factor in women's decisions to use or reject contraception, and acknowledging this factor is critical to protecting the reproductive health of young women.

In this paper, I contrast biomedical definitions and determinants of infertility with local definitions and determinants of infertility and outline the history of national population policy within the context of community mores of marriage, sex and parenthood. I argue that young women in Bali Nyonga, though having relatively more freedom to shape their future than in past generations, are also increasingly vulnerable to disease and poverty. Similarly, towns such as Bali Nyonga benefit from increased growth and diversity in modern times but their residents see a future of increased vulnerability to external economic and political forces. As everywhere, an important determinant of the future development of Bali Nyonga is the health (and particularly the reproductive health) of its youth, therefore, community planning and family planning must address the reproductive health concerns of young women, specifically infertility. This paper echoes the argument established by Inhorn and Feldman-Savelberg that understanding locally recognised causes and treatments for infertility can help improve national reproductive health strategies.

Background

Bali Nyonga lies 23km southwest of Bamenda, the provincial capital and had a population of over 23,000 at the time of the research. It has the high-land topography, monarchical political structure and history of colonisation first by the Germans, then British forces common to Grassfields cultures. Bali Nyonga is, however, unique within the Grassfields historically (settled by a conquering tribe and place of the earliest Basel mission school) and linguistically. It remains one of the three major kingdoms and is second in importance only to Bamenda as a regional market centre.

Throughout the region, the patrilineage is the fundamental concept for individual identity, family structure, residence patterns and community organisation. The patriline is built on polygynous marriage, which remains common to those men within the traditional structure who can afford it. Upon marriage, a woman goes to live in her husband's compound, which may include the houses of his father and/or brothers and their wives. A wife retains membership in her father's patriline, her children likewise belong to her husband's lineage. The patriline includes the living, the dead and unborn as members, and threats to its existence logically supersede individual concerns. Infertility is thus a problem for all of the patriline's members, which adds to pressures felt by a childless woman or couple. The family head is the embodiment of the line of succession chosen for life to rule over all of the members of the patrilineage. His role as decision-maker and progenitor of the successive generations determines the fate of the whole family to some extent. All other members of the patriline are subordinate to him, no matter their relative age or accomplishments. The family head is responsible for the spiritual, physical and economic well-being of the family. These conditions are intertwined in the relationships between living and dead.
family members. As a family head serves as intermediary in disputes among family members, he also calls upon the ancestors to look favourably on his kin. The fon, as head of the royal family, is father to all Balians, and the major rituals of Bali Nyonga tradition centre around his physical and spiritual power as protector and insurer of prosperity of the kingdom. The ramifications of royal fertility for the entire community are complex and far-reaching, as Feldman-Savelsberg has discussed in the context of another Grassfields kingdom. Vonn, a men's secret society, which annually aids the kingdom of harmful forces and ensures the fertility of its soil and people, is the other major traditional politico-religious institution.

The state is represented in Bali Nyonga in the form of the sub-divisional officer, the sub-division hospital, agricultural extension offices and a post office. More influential is the daily lives of the majority of Balians, however, are the churches, predominantly Presbyterian, but also Baptist and Catholic (which runs a large clinic). Women make up the majority of the church-going population, and at the time of the research the many women's church groups were the only active, public female-led community organisations.

At the time of the research, Bali Nyonga was in the same condition of economic crisis as the rest of the country, and the attitude of the community seemed suffused with pessimism about economic prospects. In January 1994 when the CFA franc was devalued by 50% local prices of many imported food and dry goods suddenly doubled and other prices followed. Although the coffee prices doubled with devaluation, only a few farmers had retained coffee trees after the market crashed in the late 1980's. Meanwhile, the slumping market for locally grown foodstuffs was a subject of daily concern. The market continued to decline after weathering a five-month strike by civil servants.

Methodology

The data for this paper are mainly drawn from a series of church, youth and neighbourhood group interviews conducted at the latter part of a twelve-month research project in Bali Nyonga on treatment choice for infertility. Twelve of the fourteen groups interviewed were pre-existent, the other two were recruited to ensure inclusion of adolescent girls and older men. All discussions were in variants of Cameroon Pidgin English, the local lingua franca.

Prevalence of Infertility

Attention to rates of fertility in Cameroon by demographers is not new; however, the relative importance of the issue to national politics, health policy and medical technology has been quite varied over the last several decades. Like many sub-Saharan African countries, Cameroon had a pronatalist population policy from independence (1960) until the 1980s. The National Fertility Survey of 1978 served to heighten interest in the “sterility phenomenon”, with household survey results showing the percentage of women never pregnant, those who never achieved live birth, and those without any living child broken down into age, education, province, urban/rural, and religion categories; and compared to other African countries. An astonishing 13.9% rate of primary infertility was reported. Primary infertility measured in the 1991 demographic and health survey was the highest of the 27 countries studied by Ericksen and Brunette, at 10.3%. There is a great deal of variation within Cameroon, however, with highest rates in the northern Muslim provinces. The North West Province rates of infertility were in fact among the lowest, but perception of the problem was and is great for two reasons — a relatively high ideal family size and Anglophone “nationalist” views of minority status.

Cameroon as a whole is considered to be part of the central African “infertility belt” stretching “from southwestern Sudan and northeastern Zaire across to Cameroon, Gabon, Equatorial Guinea and Cabinda Province in Angola”. The reasons for this lower fertility are not completely clear due to paucity of data, problems with survey data reliability (e.g., dependence on unverifiable respondent recall, falsification of data and inadequate interviewer training) and basic assumptions of design (e.g., “that a woman’s marital history adequately re-

There are also smaller independent Christian churches, and a small Moslem community in Bali Nyoga. Due to language and access issues, Moslem women were not included in this research.
flects her sexual history"). Two of the most likely explanations are elevated infection rates of diseases that affect reproductive organs (particularly the STIs - gonorrhoea, chlamydia, and syphilis) and having intercourse at a young age when reproductive organs can be damaged. The risk factors for STIs for African women have been attributed to three sets of factors in epidemiological studies - sexual histories, geographic residence and socio-cultural context. In their article "Patterns and predictors among African women: a cross-national study of twenty-seven nations", Ericksen and Brunette explained the assumptions involved in calculating risk. In the absence of direct measures of women's sexual behaviour women's partnership history is often used as a proxy, with divorced and separated women more at risk than married ones, and those with a history of multiple partners more at risk than monogamous ones.

Given that the increase in shorter term lateral marriage strategies are due in large part to economic instability for women and children, as Guyer and Bledsoe have shown, the rate of STIs and, therefore, infertility is likely to increase as well. Interestingly while the risk for STIs is much greater in urban areas than rural, Ericksen and Brunette found that the size and demographic heterogeneity of the urban areas do not appear to affect this pattern, since the chances of being infertile are the same in both large cities and small towns and always less likely in rural villages.

Biomedically and Locally Defined Causes of Infertility

According to demographic literature, the fertility of any population can be attributed to nine proximate determinants, namely, proportion of women married or in sexual unions, frequency of intercourse, postpartum abstinence, lactational amenorrhea, contraception, induced abortion, spontaneous intrauterine mortality, natural sterility (3% of women of reproductive age) and pathological sterility (sterility caused by infections especially STIs). According to Bongaarts et al, all variation in fertility is by definition attributable to variation in one or more of these variables. For sub-Saharan Africa, the most important determinants in limiting fertility are breastfeeding and postpartum abstinence.

Although duration of breastfeeding and postpartum abstinence have been declining in Cameroon as elsewhere in Africa, the high variability in regional fertility rates is attributed to pathological sterility. The interaction of these three determinants results in higher fertility. Taking Kenya as a model for other sub-Saharan countries that experienced recent rapid fertility increase, one study notes that a rise in fertility in many countries of sub-Saharan Africa may be inevitable. This statement is especially true in countries where the durations of breastfeeding and postpartum abstinence are still long or where the prevalence of pathological sterility is high. Moreover, the mere presence of infertility in a society will impede the acceptance of contraception because the risk of becoming sterile makes childbearing uncertain, which in turn tends to weaken individuals' interest in controlling their fertility.

This scenario can explain the Cameroon experience — while rising fertility rates have become targeted for reduction at national and international levels, the focus of attention at the level of individuals and families has been pathological sterility. Family planning campaigns that promote contraception without addressing infertility miss the "target population" and, therefore, overall fertility and pathological sterility remain high.

What then are the causes of pathological sterility? Intercourse and delivery at a young age contribute to infertility in several ways. First, the period of "initial infecundity" is longer. In addition, physical complications such as vesico-vaginal and vagino-rectal fistulae may result in permanent sterility because infections associated with fistulae can spread to the fallopian tubes. Less immunological resistance to STIs among very young women can also lead to permanent sterility. A brief report of a survey of adolescent mothers in four administrative divisions throughout Cameroon shows two findings relevant to infertility in this population. First, while knowledge of AIDS and its transmission is high it did not correspond to adoption of

"The elimination of breastfeeding and postpartum abstinence would account for 72% of fertility increase in sub-Saharan Africa, whereas in Asia it is less than 50%, Latin America less than 20%."
safe sex practices; only 12% reported using a condom. The situation with other STIs that can cause infertility may be similar. Also, it is reported that 15–38% of adolescent girls give birth at home. This poses a health hazard to the girls sometimes with fatal consequences or permanent disabilities in the case of complications. Such disabilities include vaginal fistulae, a leading cause of infertility. Another study based on a 1996 survey of 1,600 urban Cameroonian adolescents found that 55% of the females were sexually experienced (only 8% were married) and 10% of sexually active females had had a STI during the previous year.

Bali Nyongan's explanations for infertility (gleaned from my ethnographic research on treatment choice for infertility) went far beyond the nine proximate determinants into the realm of social and spiritual relationships. While the first response from older people referred to the unknowable "God's will," the typical respondent cited many possible causes. One middle-aged woman in a Christian women's fellowship (Presbyterian) group was particularly articulate, listing, in addition to natural sterility, early sex, multiple partners, use of "crude drugs" (to avoid pregnancy) and untreated venereal diseases ("gonorrhoea and syphilis and all the like"). She added that the latter diseases and diabetes also affect male fertility. Too many abortions and the use of birth control pills were cited in all groups interviewed; less common causes were having sex without removing tampons and malnutrition from food taboos. Paradoxically, though use of contraception is commonly thought to "spoil the womb" and cause infertility, epidemiological surveys show that whenever past contraceptive use is associated with infertility it is 'never users' who are more likely to be infertile, presumably because women who have difficulty conceiving have a stronger motivation to avoid contraception. This is an instructive point for reproductive health service providers in places like Bali Nyonga and elsewhere where fears of infertility are heightened due to economic and social upheaval.

Writing about pregnancy loss in Cameroon, Savage (1996) describes a holistic view of health and illness applicable to Bali Nyongans. Reproductive morbidity, or the inability of a woman to bring forth an offspring, whether through failure to conceive, miscarriage, stillbirth or infant or child mortality is therefore an indication of disharmony with the living and/or between the living and the dead. Within the context of traditional society, health is therefore perceived as a harmonious state where the social/religious or supernatural realm clearly impinges on physical and psychosocial well being. Pregnancy, par excellence, is one of these states.

Many examples of this perception of health and of the disharmony of infertility were given throughout my research. In the women's discussion group cited above, one middle-aged woman said that lack of "tradition" may cause infertility. If the marriage was done "behind the door" (in secret) without "tradition" (family acceptance, ritual, etc.) then children will not come of it. Even if the couple goes to a hospital no physical explanation will be found ("no sick for they skin"). She attested to seeing cases that finally resulted in pregnancy only after performing the traditional marriage rites. Thus, when social rules of marriage process (which maintain harmony between families and their ancestors) are not followed infertility results until balance is restored. Similarly, if one breaks the prohibition against seeing the powerful and dangerous Voma fertility cult fetish, sterility, miscarriage, obstructed labour and other maladies will occur until special treatment by Voma is given.

The state of health and fertility may also be threatened by witchcraft. Witchcraft is different from the "tradition" causation in its origins. Instead of omitting or breaking a social norm, witchcraft stems from the more volatile and unpredictable human emotions of jealousy, envy, spite and greed. Savage gives a hypothetical example of how feelings about bride price payments made over time from the husband to the wife's family can set off a crisis. He explains that feelings of resentment may develop and with time be transformed into malevolent thoughts, finally giving way to curses, evil spirits, sorcery and witchcraft. Often the young

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"Another explanation of "natural" infertility was put forth by a younger woman; that the couple's blood may not be compatible ("their blood no meet up, blood no gree [agree] for get pekin"). Thus, a pseudo-scientific explanation has been added to the traditional and Christian religious explanations of natural (morally neutral) infertility.

Pamela Feldman-Savelsberg has written extensively about this theme in Bangangt, a West Province kingdom. See especially Plundered Kitchens, Empty Wombs: Threatened Reproduction and Identity in the Cameroon Grassfields, 1999, University of Michigan Press.
couple are oblivious of these sentiments until they start experiencing problems especially the inability of the bride to conceive or carry a pregnancy successfully to term. In such a case action must be taken to deflect or placate the witch and repair the relationship between affines in order to restore the woman to fertility.

Many examples from discussion groups, interviews, and casual conversation confirmed witchcraft as a determinant of infertility. Witches can obstruct or prevent pregnancy and cause miscarriages. Jealous female relatives are most often responsible, namely, husband’s sister, co-wife, even the wife’s own sister may “chop pekin” (“eat” the child/fetus). A variation on this common scenario was given by a young woman youth group member: “Some people are jealous of others, then go about consulting traditional doctors and they destroy the other’s womb. They may contact traditional doctors to [interjection by a male: “poison somebody”] destroy the womb.” Thus, traditional doctors can assist in causing infertility directly by performing abortions and indirectly by placing a curse, or by supplying poison.

There is another form of witchcraft that is more often responsible for the deaths of already born children but can also cause miscarriages. A parent may trade a child’s life for power and/or wealth as a member (or aspirant) of a witchcraft society. In Traditions, Tales and Proverbs of the Batu Nyonga, Samuel Fe Tita Mangwa explains how witches do their evil and powerful work, even from a distance, and how people who have no witchcraft yet can receive it in their hearts. Once the magic power is bought by a person he may use it to destroy his children. These are generally greedy people to whom God has given many children.

Therefore, while suspicion may only rarely fall on a parent for preventing or terminating pregnancy, parental culpability for their own childlessness is possible. Agnes, one of my research case studies, had suffered several miscarriages during her marriage, and she said that her in-laws and co-wives blamed her for her own infertility. Though she does not fit the profile of having many children, the fact that she was the (youngest) wife responsible for collecting her husband’s rents and other revenues may have left her open to accusations of greediness and of an unwillingness to share or spend money on children (being stingy to his patrilineage). From this view, any woman without children is by definition self-centred, and this threatens household and patrilineal cohesion. This self-centred aspect of childlessness is compounded in the case of an educated woman who by virtue of her willingness to “chop” family resources for her education may already be seen as an object or originator of witchcraft. Being selfish is counter-intuitive in patrilineal logic. Being stingy with children is one of the worst forms of selfishness. Ba Feh Tita Mangwa imagined a nephew insulting a barren aunt: “When they asked you to get married and have your own children you said it was better to go hadoting around and living a free and care-free life, because a saku (prostitute) will not have time to get children.”

The interpretation of who is to blame for childlessness, the jealous relative or the greedy spouse, can simply depend on whose version of the problem is accepted. An accusation of witchcraft can thus either lighten or worsen the blame visited upon an infertile wife, depending on who is accused. Savage argues that where a pregnant woman does not build necessary social support systems with kin and neighbours her miscarriage is viewed as her own fault. An inability to cultivate this social network is indicative of negative attributes in character (“bad fashion” in Pidgin), malicious behaviour and a lacunae in her personal relationships. Considering the dynamics of patrilocal marriage, the lack of supportive social relationships of a young wife in an unfamiliar compound is presumably not an uncommon problem. Savage’s point is instructive — the value of incorporation of individuals in strong social networks is reinforced by ignoring or even blaming the less incorporated women who, by not having children, further isolate themselves. Women who are more independent of the local social networks by virtue of their education and/or wealth derived from outside the patrilineal agricultural system may not be subject to this type of sanction. But they can still be blamed for their infertility on the basis of assumed or real sexual behaviour.

One young woman described one of the causes of infertility combining elements of “God’s will,” another’s malice, and one’s own “greedy” desires. “In the case of someone going into marriage, you must not boast and say you will give birth, even if you do have a child you must not boast because
you never know. Sometime when you give birth someone will see it ... he/she will decide to destroy your womb without you knowing. So if you go to get married, don’t keep in your mind that you must have children. Tell yourself, ‘if God gives me I’ll take them and if God doesn’t I’ll bear with what has happened in my marriage.’

There are three key features to this and most other emic explanations for infertility. The first is that one may not know the “true” reason for one’s childlessness. Incomplete or incorrect bride wealth payment, a jealous relative, seeing Voma, a witch, or one’s own malevolence could all be possible causes, but one may not be aware of their existence. Secondly, infertility can be caused intentionally or not. It may be unwittingly self-inflicted by “boasting” or being arrogant or proud. Witches who eat their own or others’ children are said to do so intentionally. Most important to the reproductive health of women is the implied intentionality of those who engage in risky behaviour such as premarital sex, taking birth control pills and having an abortion. Thirdly, the interaction of two or more of these causes may be responsible, as succinctly illustrated in the last quote. Though I have discussed them separately, the interrelationship of various causes in live experience makes their sequence and boundaries indefinable.

Responses to Infertility
What women do in response to the problem of infertility is greatly influenced by the causal explanations of their predicament. The concern with diagnosis explains the importance of divination to the process of health and child seeking. Divination from the emic perspective includes all sources of explanation as to cause including laboratory tests, nganibe (traditional diviner) cowries, the Bible, and so on. The interpreters of these explanatory sources multiply possible reasons and necessary actions. From Savage’s point of view, because women are vulnerable to heavy social pressures to reproduce, they engage in health-seeking behaviour, which follows contradictory logic, powerless to disengage from the search for children.

Women take risks to achieve successful pregnancy, sacrificing their well being and dignity in conforming with the requests of health practitioners, both modern and traditional. Doing nothing to redress pregnancy loss or childlessness is tantamount to a personal admission of failure and of irresponsibility. It is also perceived as an overt admission of guilt of having sold or pledged her babies (even before conception) to supernatural forces in return for personal gratification such as longevity, wealth and success.

In this view, a woman’s tenuous social status hinges on her successful reproduction. The economic dimension of reproduction is also pertinent to health-seeking behaviour. Bledsoe, studying the Mende of Sierra Leone, found that number and status of children reflect the political and economic relationship of their parents. The “logic of polygyny”, which dictates that a woman can make demands on her husband by virtue of having his children, means that a “sub-fertile” wife or co-wife must regain her fertility in order to maintain her own economic security. Guyer’s influential paper on sub-Saharan nuptality described a shift in marriage/fertility configuration from lineal to lateral strategies, from long-term to shorter term logic on the part of both men and women. Economic decline has led to less security for women in their marriages, leading to tenuous or marginalised marriages such that women seek support in temporary relationships. The variations of the logic of polygyny remain where marriages weaken — “serial monogamy”, “informal unions”, “polyandrous motherhood”, “deuxième bureau”, — all may be seen as causing similar responses to infertility.

National Population Policy
The disparity between biomedical definitions and local definitions of infertility has implications for both public health policy and education interventions. In the recent past, the national population policy reflected local concerns about rising infertility. The 1985 Conference on the Sterility Phenomenon in Cameroon stated the following “Advice to the Masses”:

"In that case why someone don ask am, truly na say you no get to boast say, you must born, even you don get pekin for house, you no get for boast because you don born, some man go see am say you don born, i go decide for destroy your womb, privately why you no go know. So if you go for marry house why you no get pekin, if you wan go for marry house no bear in mind say you must get pekin. Talk say if God give me i go take am and if God no give me i go bear why i be come bear am for inside marry house."
1. Considering the practices of rather too easy involvement in sexual activity and the low age at first marriage in the zones experiencing high fertility.

2. Considering the importance of sexually transmitted diseases as one of the important causes of sterility and its adverse consequences on the health of mothers and children yet unborn.

We wish to inform the masses, especially the youth that:

1. the most favourable age range for producing children in stable conditions and in good health is between 18 and 35 years.

2. precocious sexual relations and sexually transmitted diseases are among the principle causes of sterility.¹⁴

Scholars from many disciplines contributed to this conference publication, with articles ranging from “The role of genetic factors in the aetiology of sterility...”, written by a geneticist, to “Educated consideration of the sterility question”, by a priest (excerpted by a physician), and “Psychosocial aspects of infertility in the North West Province of Cameroon”, by a sociologist/social worker. These substantive issues articles are followed by a set of population policy issues. Taken together, the conference publication gives a strong impression of academic and scientific concern about the sterility phenomenon in Cameroon in the 1980s.

The one article that presages the radical shift in focus to population control is “Economic implications of sterility.” The author, Sally Vega, summarises the interaction of national population and economic policies since independence. She concludes by stating that the population had grown sufficiently to fuel economic growth. Given this development, national economic needs then shifted to reduced population growth, and even individual women’s economic levels were stable enough to mitigate the cultural sting of natural sterility. Thus, a condition that is considered as horrible in one economic system could indeed constitute a positive factor in another. It is our considered opinion that as more women accept modern contraception (voluntary sterility) in Cameroon the phenomenon of sterility will pass into oblivion as a national problem and will continue only at microscopic level among individuals and their families.¹⁵

There are several points here that need elaboration in the context of infertility in Bali Nyonga. First, Vega’s take on the future direction of national population policy was accurate. Whether the emphasis on family planning was caused by economic development or decline, the “phenomenon of sterility” has certainly passed into oblivion as a national concern, even though the most recent national survey conducted in 1991 showed a continued mix of high total fertility and problematic rates of infertility and wasted pregnancy. Despite the strong fecundity observed, a significant percentage of women (26%) had, in the course of their life, at least one pregnancy that did not end in a live birth and an important proportion of women remained sterile (7% of women aged 35–49 years), even if this total sterility seems to have decreased since 1978 (11% in the National Fertility Survey).¹⁶

Yet the demographic trend in Cameroon that receives most concern nationally and internationally is rapid population growth. The population has grown from under 6 million at independence to 7.6 million in 1976, and 12 million in 1991. The average number of children per woman was an estimated 5.8 in 1991.¹⁷ Even though this total fertility rate (TFR) is down from 6.4 in the 1978 survey, with the current growth rate of nearly 3% a year, Cameroon’s population is now 15.5 million and will reach 21 million by 2010.¹⁸ Indeed, by 1995 the World Bank Report, “Cameroon: diversity, growth and poverty reduction”, focused on economic policy from a poverty perspective, noting the consequences of declining GDP, soaring unemployment and infrastructural decay. It is now a rare exception to find public sector facilities — schools, hospitals, clinics — with adequate supplies to fulfil their tasks unless these are supplied by a foreign donor.¹⁷ This is a far cry from the independence era characterisations of Cameroon’s economic potential. Therefore, national government and international donor population policy and programs focus on

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¹⁴Malgré la forte fécondité observée, une part importante de femmes (26%) ont eu, au cours de leur vie, au moins une grossesse qui ne s’est pas terminée par une naissance vivante, et une proportion importante de femmes restent stériles (7% des femmes de 35-49 ans), même si cette stérilité totale semble en baisse depuis 1978 (11% à l’ENF).
reducing family size. (The greatest irony of all may be that the increased fertility has been attributed largely to a reduction in the historically high incidence of pathological sterility in Central Africa resulting from widespread STIs). 19

Vega's mention of "natural sterility" may have been used intentionally, with the knowledge that most of the infertility in Cameroon's population is not "natural" (i.e., caused by congenital reproductive problems) but pathological, caused by STIs, abortions and the like. This distinction between natural (God's will) and unnatural/pathological is perfectly recognised by lay people. For Bali Nyongangs, unnatural infertility is caused by someone, the woman herself through dangerous sexual activity, use of birth control pills or abortion, or by malicious family members and friends (living or dead).

The discovery of three recent abortions and dismissal of three pregnant students in a Bali High School occasioned an assembly for the female students including the warning: "if you have repeated abortions there will be a time you want a child but it won't come, or it will come with many complications and you'll blame God for your own cause."

Pathological infertility is not mitigated by individual or national economic growth. It remains a significant moral, social, political and economic situation no matter what the external economic context. Here, looking at "unnatural" infertility or "pathological sterility," some of the core concepts of fertility and reproduction are shared by demographers, economists, health workers and lay people.

The prevention of premarital/adolescent sex is a common objective, since it results in the most risky pregnancies, highest rates of infant mortality, and both higher population (since the lifetime fertile period is extended earlier) and higher probability of infertility (through exposure to disease, early pregnancy and unsafe abortions). Not coincidental is the threat to gerontocratic social structure by uncontrolled premarital sex (especially among girls). 6 Concerns for adolescent fertility are at the forefront of epidemiological and popular attention, as the 1991 demographic and health survey showed a drop in median age at first birth in all age categories compared to the 1978 national survey. 16 One of the principal characteristics of this heightened fecundity is the young age at which it occurs. In effect, over half of the women give birth to their first child before the age of nineteen. 16

In the North West and South West Provinces, where median age at first marriage is 17.4, 31.3% of the 15-19-year-olds were mothers at the time of the survey, with an additional 3.4% pregnant with their first child. This rate is second only to the northern Muslim provinces where female median age at first marriage is 14.8 (Yaoundé/Douala 19.0). 16

Implications of Locally Defined Causes and Responses to Infertility for National Policy

A 1995 study using interviews and focus group discussions with adolescents and adolescent mothers confirmed the negative consequences to women's health, education and even economic status of early sexual activity. Of the 1,306 girls in the study, almost 60% had become sexually active before the age of 16, 20% had used an abortion method, and 14% had had at least one abortion. 9 Sixty nine per cent of respondents were students when they got pregnant, 86% of whom had not completed their lower secondary school education. Sixty per cent of these students had dropped out of school at the time of the interview and 11-23% of the live births by respondents had died by the time of the study. 9

The authors of such studies, and many parents and grandparents of Bali Nyongangs who were interviewed, viewed adolescent premarital sex with dismay and offered recommendations and advice on how to stop it. I contend that while these people are justified in their views, and their proposals urgently needed, the question of why adolescent girls engage in sex before marriage has yet to be seriously addressed. From my research in Bali Nyongangs, I have seen that having sex, having a child, being an adult, and being a mother are all status-defining

In "traditional" Bali Nyongangs and other Grassfields groups, unmarried boys gained sexual experience with wives of older men. Children resulting from these liaisons were claimed by the women's husbands. Sexual activity of unmarried men did not affect the overall population growth rate since their sexual partners were simultaneously the partners of other men. Thus unmarried girls and young women remain the focus of both local moral and national population control efforts.

14... l'une des principales caractéristiques de cette fécondité élevée est sa précoceité. En effet, plus d'une femme sur deux donne naissance à son premier enfant avant l'âge de 19 ans.
(and self-defining) actions at the core of economic instability and social change. As a girl's options for adulthood still hinge on the ability to have children, the condition of and responses to infertility are, if anything, more crucial than in past generations. Though my research is indeed at the micro level of individuals and their families, I believe that since infertility and hyper-fertility (population growth) are interlinked in people's lives, the sterility phenomenon will pass into oblivion as a national problem at Cameroon's economic, political and social peril. Factoring in the HIV/AIDS epidemic to this equation of fertility determinants means the fear of and response to infertility will only increase. Greenhalgh's critique of contemporary fertility theories holds true in the case of Cameroon: the human drama of fertility decline is now reduced to a technological issue, one of the adoption of a modern innovation — contraception — through diffusion. She calls for a demographic approach to fertility that sees reproductive life as, in S. Ortner's words, a relatively seamless whole. Not to decide which level/motivation is primary, but how they fit together.

Conclusion
The local concerns with and responses to infertility described here are not currently addressed in the national population policy. The national policy shift from pro-natalist to population control is in line with international (western) goals, but it is out of sync with its own population. The simultaneous demand for and fear of contraception makes sense in the local situation of economic and social uncertainty — people want control over their fertility to the extent that they can have a child when desired. Family planning policy and program designers, therefore, must listen to the women in rural towns like Bali Nyonga, as their reproductive health is critical to their personal, family and community security. Working with existing women's groups and developing safe forums (not limited to school settings) for young women to discuss their own future plans will be the most basic component of any strategy. Cross-generational discussions may also be effective for information gathering and dissemination. The information that women can provide conceiving their knowledge and experiences of infertility can guide family planning and reproductive health service provision as well as education methods. Given that the Bali Nyongan descriptions of fertility's causes, responses and meanings are interconnected in physical, metaphysical and social realms of knowledge and action, they also demand such a holistic approach to reproductive health.

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REFERENCES


