Seeking Remedies: Medical Pluralism and the Distribution of Fear

Why should I tell you about fu [medicine]? When you the white man first came, you asked so many questions about fu. Then you went home and put our medicines in bottles, came back, and sold them to us.
—mfen Meshinke’, elderly healer and subchief of Bantoum village

Don’t tell, don’t tell, Pamé. Why should they [my cowives] know that I am consulting a ngakà? They are the very ones who put something bad inside me. And they would tell our husband. No, no, it must be a secret.
—Paulette, the unfortunate protagonist of chapter 1

These two quotations from a healer and a patient both refer to the power of knowledge and secrecy in Bangangté therapeutics. They confront us with social relations of domination in the exchange of knowledge about remedies, and knowledge about seeking these remedies.

To cure and prevent the infertility they fear so much, Bangangté search for remedies from among a wide variety of medical and social institutions. Most studies of medical pluralism are concerned with the underlying cultural and social logic of the quest for therapy, including the quest for obstetric care and the quest for conception (Inhorn 1994, 1996; Janzen 1978; Sargent 1982, 1989). Because this book focuses on fear of infertility and population decline more than on illness and cure per se, we build upon these works to ask another set of questions. How might the character of these institutions, the specific form of medical pluralism in the Bamiléké area, affect the way Bangangté women think about infertility? Does the treatment Bangangté women receive contribute to their anxieties regarding threats to procreation? Does the political and economic context of medical care help shape the uses of fertility and infertility as symbolic resources in negotiations over cultural identity in a changing local and national context?

In the previous chapter, we learned that the distribution of fear of...
Fig. 13. Mfen Meshinke’, elderly healer and subchief of Bantoum village, cutting herbs for medicines. Mfen Meshinke’ quietly chants an incantation to render his herbs powerful for healing.
infertility correlates with the material and social resources at a woman’s disposition. Medical care is an important resource in treating infertility. It is also an important cognitive resource, playing a vital role in defining the problem, for example, as one of mechanical bodily failures or as the result of disturbed social relations.

As the elderly healer and subchief Meshinke’ indicated, the history of health care is closely linked to processes of political and economic incorporation in Bangangté and Cameroon. Thus, there is a history to the way population and infertility have been defined as problems in the context of the Cameroonian Grassfields. This history includes the developing definitions of infertility and declining population by colonial, indigenous, and postcolonial medical practitioners, as well as by a host of other actors (including the king of Bangangté). The ways these actors have thought about population, and have affected Bangangté women’s fears of infertility, are linked to other societal developments in Bangangté and in Cameroon as a whole, particularly those of labor migration, schooling, and the politicization of ethnicity.

These are the same actors whom Bangangté women must address when they seek cures for their reproductive complaints. The existence, organization, and premises of the health-care alternatives among which a woman must choose have been and continue to be shaped by the historical processes of the changing power and meaning of the kingship; colonization by Germany and France; regional, national, and international trade; the development of a national Cameroonian government; and the presence and guidelines of foreign aid agencies. As historians of health care in Africa have shown, government and missionary definitions, regulations, and policies have repercussions at many levels of health and health care (Comaroff 1981, 1993; Feierman 1985; Hunt 1993; Packard 1980; Vaughan 1991).

None of the health-care institutions in Bangangté treat exclusively reproductive problems. Some even combine the treatment and prevention of illness with other services such as providing mystical help for business deals, journeys, and school exams for individual clients, or serving the mfen and the royal court by identifying the place and timing of rites needed for maintaining agricultural success and social contentment throughout the kingdom. A woman seeking help for reproductive problems is often familiar with a particular healing institution or specialist from previous interaction regarding another type of service. This interweaving of medical, ritual, and pragmatic specialties underscores the integration of health care and health seeking with other domains of Bangangté social life. But integration and familiarity do not provide a sense of protection from reproductive threats.
Seeking remedies for reproductive complaints, an individual woman’s quest for therapy can contribute to the fear of infertility. As in Paulette’s case, practitioners may channel relatively vague physical complaints into categories of reproductive and social disorder. The vagaries of access and confidence in the many forms of health care (will I be able to find my healer? can I pay for transportation and consultation? can I trust that my treatment will be effective or at least not harmful?) further contribute to Bangangté women’s frequent feelings of hopelessness and despair in confronting the risks of reproductive illness. The worries expressed by Bangangté women suggest that there is a cognitive parallel to the iatrogenic effects of infertility treatment pointed out by Inhorn (1994).

Remedy seeking goes beyond the quest for therapy in a strict sense. It is part of the management of social relations, as evidenced by Bangangté women’s emphasis on discovering the cause of affliction (in relations with the living, the dead, and the divine) rather than with concern for therapeutic efficacy, for seeking conception. Here the Bangangté case differs from the plight of Egyptian women as eloquently portrayed in the only comprehensive account of non-Western women’s experiences of infertility (Inhorn 1994, 1996). Inhorn cites many cases of women who vow never to end their peripatetic “search for children” (1994:xxvi). Through their quest for conception, these Egyptian women are managing their social relations, in their marriages, with their kin and neighbors, and in response to clerics and national policies (Inhorn 1996). The Bangangté women I know seemed less concerned with ameliorating social relations by finally achieving motherhood than with knowing how to recognize and avoid the danger of someone harming their reproductive capacity.

Janzen’s now classic discussion of kinship therapy among the Bakongo clearly illustrates the management of kinship, marriage, education, and wealth in African healing systems (1978a). In a later work, he shows how intimately a specific therapeutic form, the Lemba “drum of affliction,” is entwined not only in healing but also in managing market and political relations of those living in the interstices between African kingdoms (1982). The management of social relations through therapy seeking in Bangangté reaches beyond the scope of the therapeutic encounter among patient, kin, and healer. The public and social character of therapy management is peculiar in the case of infertility treatment. As Inhorn points out for Egypt (1994) and as evidenced by Paulette’s plight portrayed in chapter 1, therapy management groups tend to collapse over time. In addition, the act of seeking remedies is itself a socially sensitive endeavor, bringing with it potential social costs. As Paulette indicates in the second quotation introducing this chapter, although patients may
make enormous investments in time and money seeking cures for reproductive afflictions, secrecy and privacy play a tug-of-war with a wish for attention in the patient’s management of therapies.

Remedy seeking also goes beyond the quest for conception because Bangangté women’s concerns are broader. They worry not only about individual fate and individual fertility, but also about social reproduction. Their management of social relations includes a concern with internal and external threats from witches and from the complexities of local–state relations. They force us, as analysts, to place theses regarding therapeutic choice in medical anthropology in broader context, to see how individual variables interact and combine and how this interaction is conditioned by historical and political-economic forces.

The first part of this chapter investigates the historical processes over the past century that shaped the number and kind of health-care institutions in Bangangté today. The second section describes the health-care alternatives currently available for Bangangté women to consult regarding reproduction. It examines these health specialists’ contending approaches to healing and their current attempts to adapt to a field of competing health-care alternatives. The third section analyzes the social relations of the therapeutic process, in other words how women and their kin go about managing crises in reproductive health, how they seek out health-care specialists and cures, and how their social situation affects their access to and use of various forms of health care. The chapter concludes with some propositions regarding the effect of social differentiation on access to health care and thus indirectly on the distribution of fear of reproductive illness in Bangangté.

**The History of Health-care Alternatives in Bangangté**

How did those white men described by the elderly healer and subchief Meshinke’ come, learn about, and steal Bangangté medicine? At first European knowledge of Grassfields society and therapeutics was quite sketchy. The earliest colonial reports indicate an active indigenous attempt to counteract the disruptive effects of the establishment of colonial government and labor recruitment through the development and trading of “medicines” aimed at strengthening the kingship and counteracting witchcraft. As the colonial era progressed, first the German and then the French colonists attempted to establish medical hegemony, combining humanitarian and paternalistic good intentions with a wish for control. Government medicine was aimed mainly at insuring the labor capacity of African men, focusing on nutrition, epidemics, and enumerating populations. They viewed women’s role as fertile producers of, variously, laborers,
rural traditional order, and food (Guyer 1987; Vaughan 1991:22). Missionary medicine aimed to create a new type of African, an individual who would resist the collective will of “tradition” and “superstition” to embrace Christianity. Missionary doctors used dramatic surgery to draw converts and focused on mother–child health care in the long work of changing hearts and minds.

German Colonial Encounters with Grassfields Therapeutics

The earliest European inquiries into Grassfields modes of healing were based on reports on public ritual, herbal medicines, and foodways written by German explorers, researchers, and military officers at the time of direct European contact, on the eve of the twentieth century. Working their way north from the port city and administrative center of Douala and from the plantation area of southern Cameroon, they focused on three areas. First, an interest in the role of sorcery and medicine in royal hegemony and interkingdom diplomacy emerged from concern with the ability of indigenous Grassfields to assist (or resist) labor recruitment efforts. Second, investigations into indigenous foodways were tied to colonial concerns with the suitability of Grassfields populations for labor. Third, the discourse on sexually transmitted diseases and infertility was likewise linked to the colonial need for labor for railroad construction and plantations in southern Cameroon.

German travelers and researchers on indigenous medicine were struck by indigenous attitudes toward death and fear of sorcery. They contrasted Grassfields “fatalism” to their own “rational” and “scientific” biomedical beliefs. Fatalism, for doctors Preuss and Ziemann, was evidenced by the ways Grassfields peoples attributed deaths from pneumonia and other illnesses to the guilt of another party who has made a “fetish” (Preuss 1891b:143; Ziemann 1904:153). Behind this colonial criticism, we can hear the cries of a region suffering from the introduction of new microbes. We can also discern an indigenous theory of sociogenic etiology, that is, that disease is caused by disrupted or harmful social relations, now so familiar in contemporary studies of African therapeutics across the continent.

Conrau, author of the first travel report that includes the Eastern Grassfields, noted the relation between the fear of sorcery, royal hegemony, and the interethnic trade in indigenous medicines. Residents of the Noun River valley, which separates Bangangté and Bamoum, bought medicines from neighboring groups to cure illness and prevent theft (Conrau 1898:196–197). In the Western Grassfields, a newly acquired medicine or “fetish” that was meant to strengthen the king against supernatural attack, again bought from a neighboring people, was displayed at the nobles’ meet-
inghouse at the palace in Bangwa-Fontem during Conrau’s 1898 visit (Conrau 1899:202). Both the king of Bangwa and his nobles complained to Conrau about “lawlessness” and the increasing incidence of witchcraft in the Grassfields. Such threats to royal hegemony were counteracted by rituals to maintain public peace and prosperity, including “blood friendship” pacts struck among prominent Grassfields kings (Hutter 1892:176–84). It appears that a concern for the safety of kings and the kingship, and thus with the maintenance and reproduction of a specific form of social order, arose at a time when the disruptions of colonialism were first being felt in the Grassfields. As we have seen, in systems of divine kingship social order is closely linked to individual health and fertility. Similar complaints arose during the 1980s, another period of changing power relations between Grassfields kings and larger, external political forces.

The context of these reports indicates that indigenous medicine at the turn of the century struggled to respond to the context of colonial labor policies. Labor shortages created by the competition among planters, traders, and colonial administrators for workers necessitated the use of migrant labor (Rudin 1938:316). During the earliest years of German colonization, workers were imported from other parts of West Africa. After the interior became subject to colonial control in 1898, labor recruiters sought plantation labor, porters, and public works laborers in the Grassfields area surrounding Bali, Bamenda, and the Bamiléké highlands. Some local rulers seized the opportunity to solidify their hegemony over their neighbors, supplying plantation representatives and traders with laborers in return for colonial patronage; this system was formalized through labor contracts drawn between various Grassfields kings and the German colonial government (Rudin 1938:320, 322).

Working conditions and methods of labor recruitment were devastating to workers’ health. Forced from their homes, workers were bound together by ropes and made to trek long distances, often through areas of smallpox epidemics, to reach their destinations (Rudin 1938:324, 326). Arriving in the hotter, wetter, lower altitude plantation areas, climatic change contributed to the suffering of Grassfields workers, especially from malaria and filariasis (DeLancey 1978:158, 160). The death rate in the colonial plantations sometimes ranged from one-third to one-half of all plantation workers (Rudin 1938:328). Workers lived in barrack conditions, where crowded conditions and impure water were conducive to the spread of communicable disease, including dysentery, tuberculosis, pneumonia, and typhus (DeLancey 1978:162; Rudin 1938:328). Workers’ one-sided diets of unfamiliar foods contrasted ironically with colonial investigations into indigenous Grassfields foodways; rather than seeking continuity in migrant workers’ diets, researchers proposed changes in
Grassfields agriculture, encouraging peanut and black bean cultivation (Reichskolonialamt 1914:84; Wissenschaftliche Beihefte 1894:99–104).

When Grassfields laborers had finished their contracts, they often returned home “emaciated, [and] suffering from various diseases” (cited in DeLancey 1978:167) or died in the road. They brought the scourges of the labor barracks home with them, spreading disease beyond the immediate labor areas (Doyal 1979:111) with serious consequences for Grassfields populations. Dysentery and smallpox disseminated along trade routes and into the source areas of labor recruitment, scarring faces (Ziemann 1904:160) and devastating local populations. In 1910–11, 8000 people in Bamenda district died from a dysentery epidemic (Reichskolonialamt 1912:56). But the same page of the official report on the fight against disease in Bamenda discusses increases in the recruitment of indigenous labor for the Mittellandbahn, the railroad between Douala and Yaoundé (Reichskolonialamt 1912:56). The early colonial appetite for labor was insatiable and contributed to enduring local images of population decline.

It is probable that disease itself also contributed to fear of population decline in Grassfields polities such as Bangangté, as migrant laborers returned from the barracks with syphilis and gonorrhea. The areas and timing of the spread of sleeping sickness, influenza, and sexually transmitted diseases correlate strongly with pockets of low fertility in sub-Saharan Africa (Retel-Laurentin 1974). While no reliable data exists on fertility fluctuations among Grassfields populations during this time, indigenous fears of low or decreasing fertility were shared by several colonial actors, all with their own interests.

Reports of colonial officials express a repeated concern with reproductive strength in the Grassfields (Reichskolonialamt 1912:56, 58, 60; 1913:64; 1914: xii, 78). Sexually transmitted disease and poor indigenous hygiene were most often cited as causes of the allegedly declining fertility of the Grassfields (Reichskolonialamt 1912:56, 60; 1913:64). Only one dissenting voice, a perceptive physician of the German navy, included the reduction of the male population via poorly regulated recruitment of laborers and porters for military expeditions in his report on low population in the Grassfields (Ziemann 1904:150–53). During the same time period, traders were concerned not only that enough laborers be guaranteed to carry their goods into the hinterland, but also that a large and prosperous population would exist to insure consumers (Diehn 1956). A daughter of the most prominent German trading firm, Woermann, offered a cash prize for the best study on ways to increase the native birthrate (Rudin 1938:346). Missionaries were concerned with promoting the health of Grassfields populations in order to encourage and maintain followers, including medical evangelism in their efforts. The first missionary
physician was sent to a Western Grassfields Basel Mission station in 1907, and to the mission’s Foumban dispensary ca. 1908 (Basel Mission, Ärtzliche Mission in Kamerun, n.d.). But mission health care, later to focus on maternal and child health, did not become established in the Bangangté area until well into the French colonial era, during the interwar years.

The early colonial period brought a number of new diseases and an increase in the feeling of affliction even to Grassfields people who had had no direct contact with the colonizers. Not only disease, but the social effects of labor recruitment and colonial rule disturbed the health and fertility of Grassfields populations. Young Bamiléké men were absent, doing forced labor or emigrating to the urban centers to escape labor recruitment in the countryside. This led to the neglect of native farms (DeLancey 1978:157). The involvement of the Bamiléké kings, including mfen Njiké II of Bangangté, in labor recruitment weakened the mfens’ hold on some of their subjects. Those most affected by labor recruitment were commoners and those from royal retainer families, and many young men from these social strata sought to escape the mfens’ realm of dominance in order to escape forced labor recruitment. The women from these groups lost access to land gained previously through now absent husbands. They suffered more than other women from lack of resources, shrinking support networks, and malnutrition. In the absence of reliable population data, we can surmise that the wives and sisters of labor recruits suffered lower fertility due to separation from their husbands and potential mates.

As sexually transmitted diseases became endemic to the Grassfields, and as more and more migrant workers returned home sick, local forms of caring for the afflicted became strained. New social conditions may therefore have contributed to changes in healing practices in the Grassfields during the early decades of the twentieth century. The intergroup trade in “medicines” (i.e., buying herbal recipes or instructions for amulet- and fetish-making along with the skill to apply them) observed as early as 1898 by Conrau may have been stimulated by the indigenous health-care specialists’ increased need to find cures for new and more frequent afflictions. Labor migrants, like mfen Meshinke’ who complained so heavily about whites stealing indigenous medical knowledge, incorporated new ideas (e.g., “measuring” sickness) from their encounters with biomedicine. But at the same time that they sought new medicines to cure new diseases, they were hindered in their endeavors by a repressive colonial administration. In Bana district, then including Bangangté, punishment “with arms” was used against the “evil influence of so-called medicine-men, who got the population into an upset state following a murder by poisoning trial” (Reichskolonialamt 1914:70, my translation). An official report argues that low fertility and high maternal and infant mortality in the Grassfields
was not to be fought with health education, but by combating “bush medicine and wise women” (Reichskolonialamt 1912:60, my translation). To this end, plans were made toward the end of German colonial rule to train indigenous midwives in biomedical techniques of birth attendance (Reichskolonialamt 1914:80).

Bamiléké encounters with colonial biomedical practices was negligible for all but the migrants to the cities and plantations. Colonial medical services reached the Grassfields only at the very end of the German colonial period and were delivered in a sporadic and repressive fashion. Grassfields populations first encountered biomedical treatment through mobile troops delivering smallpox vaccinations (Reichskolonialamt 1911:65–67). On the eve of World War I, one official report records that a number of Grassfields kings were punished for their resistance against the vaccination campaigns (Reichskolonialamt 1914:70).

The German colonial period led to real and perceived threats to Grassfields fertility and numbers. A labor reserve area, the Grassfields were drained of young men. Those who were not recruited often fled to the bush, away from both colonial and chiefly authority. The repressive nature of early colonial biomedicine, military expeditions vaccinating against dread diseases and punishing resisters, further contributed to the flight of young men and fear of disease. Women, particularly of those social strata contributing most heavily to the colonial labor pool, suffered sexually transmitted diseases, secondary infertility, and decreased opportunities to become pregnant. These conditions set the stage for continuing indigenous images of population decline during the French colonial period, images that were exacerbated by French fears regarding population.

New Actors: French Military Medicine and Medical Missionaries

While the 30 years of German colonization affected patterns of health and most likely influenced the practices and demand for indigenous health care in the Grassfields, the availability of biomedical treatment and its impact upon the Bamiléké in general and Bangangté in particular remained negligible. After the Germans lost Cameroon in 1916, two groups of new European actors entered the field of health care in Bangangté. Although they shared the biomedical model of germ theory, specific etiology, and the notion that medicine treats the physical problems of individual patients, the French colonial military medical staff and Protestant medical missionaries had divergent goals and different relationships with the local population surrounding Bangangté.
Colonial Medical Efforts. The Service de Santé de la France Outre-Mer, a part of the French army, ran public health care in Cameroon under French mandate and trusteeship. At the beginning of French rule, public biomedical units expanded rapidly into the Bamiléké region. The French were very concerned to eliminate Cameroonians’ identification with their former German colonizers (Ngongo 1982:16–23), and increasing their presence through health services was one way to franciser (Frenchify) their new subjects. In addition, the League of Nations decision had split the Eastern and Western Grassfields between French and British mandates. The Germans had concentrated their nascent infrastructure in the Western Grassfields, while still drawing on Eastern Grassfields (Bamiléké) labor. The new French masters could draw only on Bamiléké labor, and the Bamiléké plateau thus increased in importance to its colonial rulers.

Continuing the aims of their German predecessors, French colonial military medicine sought to insure a sufficiently healthy indigenous population as a potential labor force. The Bamiléké plateau was mentioned as an important source of labor as early as 1917 (Tardits 1960:65), even before the territory was officially ceded to France under a League of Nations mandate in 1920. The value of the Bamiléké plateau as a labor reserve area became even more significant throughout the period of French rule. Influenced by the need for labor in central Cameroon, colonial medical officials were particularly concerned about (1) the devastating endemic diseases trypanosomiasis (sleeping sickness) and leprosy, and (2) an allegedly declining indigenous population.

Throughout the colonial period, the state of health of Bamiléké populations in the countryside remained a problem for labor recruiters. In 1944 the French administrator at Bafoussam, Relly, reported that he habitually demanded twice as many laborers as needed for plantation work since 50 percent were rejected by the plantations’ health service (Tardits 1960:67). In the same report Relly complained that 90 percent of Bamiléké youth fled the labor recruiters, either temporarily to the forest or for longer periods (even permanently) to urban centers. The heavy-handed recruitment policies of the French administration thus contributed to uncontrolled rural flight and an imbalanced demographic structure within the territories of the Bamiléké kingdoms.

One step in improving the health of labor source populations was combating endemic disease. Colonial military medicine organized the fight against sleeping sickness and leprosy, well-advertised medical campaigns that brought some positive recognition to France’s efforts in the mandated territory. In 1922, Eugène Jamot, a military doctor in the service of the French administration, began his campaign against sleeping sickness (try-
panosomiasis), a disease threatening the lives and productivity of central Cameroonian populations and colonists alike (LeVine and Nye 1974:59–60). Jamot established mobile treatment centers that surveyed the population for cases of both sleeping sickness and leprosy. Bamiléké contact with mobile medical services increased during epidemics; in 1945 21,095 Bamiléké were vaccinated to prevent the spread of a smallpox epidemic then raging in the Western Grassfields of British Cameroon (Farinaud 1945:3, 113). From the point of view of the Bangangté and their neighbors, these contacts were far from benign. Mobile teams rounded up local populations for vaccinations, and those infected with targeted endemic diseases were isolated in treatment colonies.

The work of the mobile teams of the Service d’Hygiène Mobile et de Prophylaxie (SHMP) that aimed to insure the native labor supply was at the same time linked to French concerns about population (Feierman 1985:121–22). Statements regarding Bamiléké population occur as early as 1928 in reports to the League of Nations. In the mid-1940s, the medical-colonel Farinaud expressed concern about the increasing rate of gonorrhea and its deleterious effect on Bamiléké fertility (Farinaud 1944:79), but felt that solving the problem of low fertility among the Bamiléké was less a medical than a social task of education (1945:204). Nonetheless, medical officers expressed concern when Bamiléké use of biomedical gynecological care diminished; a decrease in Bamiléké deliveries in government health services in 1947 was attributed to the political climate (Vaisseau 1948:66, 69).

The French were particularly sensitive to questions of population in equatorial Africa and in the metropole, but their concerns were often based on misunderstandings of social and demographic processes. Kuczynski introduces his extensive demographic study of Cameroon and Togo by criticizing French concern with population decline in the Cameroonian Grassfields as unfounded and revealing the “administrator’s lack of sense for figures” (1939:xvi). Not only was most census data based on estimates, but people also fled into the forest to avoid census takers, fearing taxation, labor conscription, and violence. Those who were actually counted had to assemble at designated points on designated days (Egerton 1938: 177–79). In addition to depending upon unreliable census data, the French occasionally frightened themselves unnecessarily about demographic threats to their Grassfields labor supply because they were ignorant of the effect of Bamiléké and Bamoum history on population distribution. The Noun valley, on the frontier between the Bangangté and Bamoum kingdoms, had been depopulated by the last Bangangté-Bamoum war at the end of the nineteenth century. A French military
physician, Cartron, was concerned with the effect of low fertility and low population densities among the Bamoum on the economic exploitation of valuable agricultural land. He suggested resettling the more populous Bamiléké as agricultural laborers in the Noun valley, never realizing the historical reason for low population in the Noun valley (Cartron 1934).

The actual effect of French rule upon Bamiléké population change seems contradictory. On the one hand, labor migration and the flight of young adult men from labor recruitment to the cities contributed to the neglect of farms and the overburdening of women with both men’s and women’s agricultural tasks in the production of food crops. It also separated husbands and wives for long periods of time, created a shortage of young men, and helped spread sexually transmitted diseases—all factors that can potentially lower fertility. In addition, now de facto female headed households were socially more vulnerable should disease or misfortune strike (Feierman 1981). These social processes began during the German colonial period and intensified during the French colonial period. Particularly after World War II, Bangangté was more affected by labor migration than any other Bamiléké kingdom (Tardits 1960:86). Current Bangangté concerns about declining population refer not only to birthrates but also to the ongoing pattern of labor migration that got its impetus during French rule.

On the other hand, certain aspects of biomedical care reduced mortality from epidemic disease, according to some reports resulting in rapid population increase (DeLancey 1978). This led to land shortage and increased labor migration, decreasing fallow periods, and declining soil fertility. When the cash crops cocoa, tobacco, and especially coffee were introduced in the 1930s, and when their production was liberalized around 1950, land for food crops became ever scarcer and the diet more one-sided. These aspects of “overpopulation” and economic change created both economic and health stresses upon rural Bamiléké populations during the period of French mandate and trusteeship. They also created the conditions for differential risks to fertility indicated by the distribution of women’s fears in contemporary Bangangté. Some households may have expanded their numbers and land use, while others were broken apart by the enforced labor migration of noninheriting males.

During the greater part of French rule, colonial health care aiming to prevent demographic decline and devastating disease in the Bangangté area was limited to the mobile teams of the SHMP. Through these mobile teams, Bangangté encounters with the medicine of their new rulers were often intermittent and overshadowed by the repressive nature of medical police. The forced vaccination of healthy individuals brought no immedi-
ate, visible benefits and made little sense to Bangangté patients. The first
government doctor treating Bamiléké patients was sent to Dschang in
1920, where a hospital was opened in 1930 (Debarge 1934:7). In Bangangté itself, the first government medical center, an ill-
equipped dispensary built of wattle and daub construction, existed during
the late 1930s and early 1940s.11 A new dispensary was constructed
between 1940 and 1943 of permanent materials and staffed with nurses
trained at the colonial school for indigenous health workers at Ayos, in
south-central Cameroon. The dispensary received its first physician in
1953, although by 1951 it already had an inpatient capacity of 57 beds
(Rapport . . . à L’Assemblé Générale 1951:212). According to oral testi-
mony, the present Bangangté provincial hospital was built in the 1940s on
the former cite of the “Hausa” (including Hausa and Fulani) settlement in
Bangangté town. It appears to have been opened only in 1960 with the
arrival of the French Médecin-Lieutenant Lassauvagerie. As with the
mobile teams of the Service d’Hygiène Mobile et de Prophylaxie, these station-
ary biomedical establishments of the Action Médicale Indigène (AMI)
were run in the authoritarian manner of the military medical services.

Protestant Missionary Medicine. As Vaughan points out in her study of
missionary medicine in East and Central Africa, “throughout most of the
colonial period and throughout most of Africa, Christian missions . . . pro-
vided vastly more medical care for African communities than did colonial
states” (1991:56). This was true in the Cameroonian Grassfields surround-
ing Bangangté as well, where the bulk of biomedical care of indigenous
populations was provided by the Protestant mission. The Société des Mis-
sions Evangéliques de Paris (now DEFAP) took over the work of the Basel
Mission in French Cameroon in 1916 and began reporting on its
Cameroonian activities toward the end of the war, in 1918. The French
Protestant mission quickly expanded its medical work, beginning with a
dispensary (clinic run by a nurse) in Foumban. The energetic Josette
Debarge joined the Foumban dispensary in November 1926 as the first
missionary doctor in the Eastern Grassfields (Debarge 1934:8). Two years
later a dispensary staffed by two nurses was constructed in Bafoussam
(Debarge 1934:10). Joining the Bafoussam dispensary in 1930, Debarge
opened a dispensary at Bangwa near Bangangté in 1931 (1934:11). The
construction of Bangwa hospital, still the most important and famous bio-
medical establishment in Ndé Division, began in 1934.

The mission’s medical work was explicitly tied to the goal of evange-
lization. The missionaries hoped to convince the local population of the
power of Christian faith through demonstrating the power of European
drugs and surgery. Daily practice at Bangwa dispensary began with the
admonition that the “tutelary spirits” would not seek vengeance on patients visiting the mission doctor (Debarge 1934:88). When the medical missionary teams arrived in a village during treatment and evangelization tours, hundreds of patients and escorts would be waiting. The missionaries preached a sermon about the virtues of Christianity and its power to heal, and the evils of polygyny, nakedness, alcohol, and “bush medicine,” to the crowd before beginning the individual consultation of patients (Debarge 1934:74). Dramatic surgical operations were explicitly used to convince royals and the Bamiléké nobility, resistant to evangelization, of the immense power of Christianity and its medicine (Debarge 1934:78).

The premises underlying missionary healing were those of traditional biomedicine of the time. The physician felt privileged to deal with the concrete body; she complained that her patients found her questions about the body’s physical symptoms incomprehensible (Debarge 1934:51). Because Bamiléké patients and their indigenous healers deal with custom and notions of angered “spirits” that are “moved by the subconscious,” Debarge concluded that they are interested in completely different information regarding illness and that it is best not to interrogate but merely to physically examine the hopefully passive patient (1934:51). For the Franco-Swiss physician, surgical operations were “an oasis of calm,” with “their ritual technique, their silence, their obligatory isolation” (1934:75). One can only imagine the deep impression the ritual of surgery must have made upon patients and their kin, and the fear the isolation of the patient from her family must have awakened.

The isolation of the patient via the practices of missionary medicine occurred in other ways as well. The largest group of patients during the 1930s, the formative years of mission medicine in the Bangangté area, was women. Debarge found sterility, infant mortality, and tuberculosis to be the most serious problems (1934:112). Bangwa’s mission doctor attributed sterility and infant mortality to the spread of sexually transmitted disease (1934:61, 62) and recognized that they were devastating to women, who suffered since “children are their reason for living” (1934:28). Building upon this felt need, midwifery, fertility, and child care became a focus of Protestant mission work in Bangwa and, by the 1940s, in Bangangté. As elsewhere in Africa, Christian missionaries found that African ideas about fertility, childbirth, and child rearing were “the locus of the reproduction of many strongly-held beliefs” (Vaughan 1991:66), the very “superstitions” or non-Christian social and moral controls that evangelization sought to change. Gradually, childbirth at mission hospitals and dispensaries became ever more common. Debarge and her colleagues focused much of their attention on infant feeding and child rearing practices, encouraging habits of regularity more fitting with the early-twentieth-cen-
tury European model of self-discipline. Infants became patients isolated from African families, first in the form of an orphanage in Bangwa. In 1946 Charles and Yvette Bergeret founded a school of home economics for girls, instituting an elaborate system of reeducation in which the students were isolated from their families, their customs, and their “pagan superstitions” (Njiké-Bergeret 1997:23).

Reports in the mission archives from the opening of Bangwa Hospital in 1934 through the mid-1960s reveal a long tradition of a well-staffed and expanding missionary health-care system in the Bangangté-Bangwa-Bafoussam area. Concern with evangelization continued, citing that the role of God’s disciples is to “chase demons” and that this is best done by serving the sick in the mission’s hospitals, dispensaries, and leprosariums (Société des Missions Evangéliques de Paris 1960:19). Maternal and child health care, long neglected by the colonial state, became a notable element of the medical mission and furthered the goal of evangelization.

The French mission gradually ceased to have exclusive control of Protestant medical work in the Grassfields. The missionaries had to share power with the Cameroonian church they themselves had called into being, the Eglise Evangélique du Cameroun (EEC), autonomous since 1957. Starting in 1961, the professional staffing of Bangwa and other Protestant hospitals was also shared between the French mission and that of the Dutch Reformed Church. The civil war of the 1960s, and a related incident in which two French missionaries were murdered in 1965, initiated a number of years during which French missionaries were totally absent from Ndé Division. The goals of the missionaries slowly changed from that of proselytizing to doing good works through health care of the poor. With this change in mission policy and attitude, some tension developed between officials of the Cameroonian church (EEC)—who are most interested in evangelization, curative medicine, and privileges for church members—and foreign missionaries dedicated to primary health care and the disregard of the hard-won status of higher level church members.

Medical Pluralism in Bangangté: The 1980s

The arrival of French military and missionary medicine and their coexistence with the various forms of indigenous health care present in Bangangté in the 1930s created a field of divergent ways of organizing health care and contending ideologies of illness and curing. Even before the permanent establishment of biomedical dispensaries in Ndé Division, indigenous medicine was characterized by its variety and innovative response to social change.\(^\text{13}\) At the time of my initial fieldwork, 50 years after the
founding of Bangwa Hospital, Bangangté women still had to manage complex alternatives when seeking remedies for reproductive ailments.

To understand how the form of medical pluralism in Bangangté affects the ways Bangangté women think about threats to their fertility, we first must grasp the entire field of health-care institutions and how they are classified and perceived by their practitioners and clients. Each of the health-care institutions in and near Bangangté kingdom has its distinctive form of organization, methods and specialties of healing, medicines, premises, ways of training specialists, and modes of interacting with patients. Each of them by and large has the characteristics of a medical system, a “patterned, interrelated body of values and deliberate practices, governed by a single paradigm of the meaning, identification, prevention and treatment of sickness” (Press 1980:3). They differ from this classic definition of medical systems in two respects. First, they are particular organizations and may share paradigms of meaning, identification, prevention, and treatment with other health-care institutions. For example, the public biomedical hospital and the public rural health clinic share the same premises regarding illness and health care, but differ in their degree of functional differentiation. Second, any one institution may refer to more than one illness/treatment paradigm, although each institution tends to emphasize what Press would define as a particular medical system.¹⁴

When seeking remedies, Bangangté distinguish among different types of healing institutions and among individual practitioners (see table 1). Most village women refer to all biomedical institutions as providing the same type of health care and working according to a single set of premises. They call biomedicine la médecine moderne (modern medicine) or fu mekat (white man’s medicine). Often a woman will have a preference for a particular biomedical institution, based on reputation or personal connection to a staff member.

Likewise, these same health seekers refer to the majority of indigenous health-care practitioners as ngakà (person of power/medicine) or as guérisseur (healer). Indigenous practitioners make finer distinctions among themselves: ngafu (persons of herbs) cure primarily with herbs, ngakà (persons of kà) combine the control of magical power with herbal treatments and, occasionally, with divination, and ngazenu (sages, clairvoyants) use their wisdom or their power to “see” to recommend therapies and perform small treatments using herbs or manipulative techniques.¹⁵ Both indigenous healing specialists and lay Bangangté distinguish two further types of traditional health-care institutions or specialists: the ngangame (diviner), who performs divination with the earth spider oracle; and the minnyi (spirit medium), a person, most often a woman, who is
TABLE 1. Inventory of Health Care Specialists and Institutions

<table>
<thead>
<tr>
<th>French Term</th>
<th>Lay Bangangté Term</th>
<th>Differentiated Bangangté Term</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Specialists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Biomedical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>médecin</td>
<td>dokta</td>
<td>dokta</td>
<td>physician; sometimes nurse; both can write prescriptions</td>
</tr>
<tr>
<td>infirmier aide-soignant fille/garçon de salle</td>
<td>dokta</td>
<td>dokta</td>
<td>nurses’s aide</td>
</tr>
<tr>
<td></td>
<td>dokta</td>
<td>dokta</td>
<td>aide, generally with formal training</td>
</tr>
<tr>
<td>B. Indigenous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>guérissuer</td>
<td>ngakà</td>
<td>ngafu</td>
<td>man of herbal medicine; uses only herbs</td>
</tr>
<tr>
<td></td>
<td>ngakà</td>
<td>ngafu</td>
<td>man of medicine/magic; uses herbs as well as divination and spells</td>
</tr>
<tr>
<td></td>
<td>ngazenu</td>
<td>ngafu</td>
<td>sage; can “see” causes, recommend therapies, and perform minor treatments</td>
</tr>
<tr>
<td></td>
<td>ngangame</td>
<td>ngangame</td>
<td>man of the earth spider; performs spider divination to find causes and predict the future; rarely cures</td>
</tr>
<tr>
<td>médium</td>
<td>minnyi</td>
<td>minnyi</td>
<td>usually female, divinely inspired or possessed; can diagnose causes, indicate which ancestor needs to be appeased, and give herbal treatments for minor maladies and to enhance fertility</td>
</tr>
<tr>
<td>II. Biomedical Institutions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hôpital (publique, privée)</td>
<td>waswita</td>
<td>hierarchical organization with many departments and role sets</td>
<td></td>
</tr>
<tr>
<td>centre de santé</td>
<td>waswita</td>
<td>rural or urban clinic staffed by personnel of varying rank, none higher than nurses; low specialization</td>
<td></td>
</tr>
<tr>
<td>CDMP</td>
<td>waswita</td>
<td>Centre Départemental de Médecine Preventive; functions as urban clinic</td>
<td></td>
</tr>
<tr>
<td>pharmacie</td>
<td>famasi</td>
<td>private pharmacy</td>
<td></td>
</tr>
</tbody>
</table>
alternately described as possessing divine inspiration or as being possessed by a “spirit,” the ancestor, or Nsi (God). Minnyis have special powers of clairvoyance, and prepare medicines to enhance their clients’ fertility or cure minor complaints such as headache.

In contrast to the attitudes of biomedical personnel and to national and international health policy makers, this inventory shows that indigenous medicine in Bangangté is neither uniform nor static, but is constituted by highly diverse and dynamic forms of healing. Furthermore, individual practitioners within each type of indigenous health institution are highly, and often purposefully, individualistic.

Some Bangangté who are specialists in other fields, such as dispute resolution, perform curative or preventive health-care roles. The bandansi, the people of the house of Nsi, perform rites of washing and oath taking supported by drinking “cooked” (mystically transformed) raffia wine for litigants in suits brought to the mfen. Often these cases involve the reproductive difficulties of one of the litigants. The following case was brought before the mfen, and resolved through the action of the bandansi.

**Infertility as a Legal Case**

The plaintiff had been married to a young woman for a number of years. She bore him two children, but one died. Since then, she has borne no more children and has been in bad health. The plaintiff “has spent just too much money” (mfen) trying to restore his wife’s health. Through his vain attempts with biomedicine, he discovered that his wife could not get well by modern medicine alone; the cause of her affliction was in the family.

In October 1986, the plaintiff accused two relations of his sick wife—her “tuteur” or guardian before she was married, and the heiress of one of her maternal kin—of making or keeping her sick. The mfen listened to the stories of each of the four parties concerned: the plaintiff, his sick wife, the tuteur, and the maternal heiress. He found no one guilty, but ordered a rite of reconciliation to be performed under the guidance of the bandansi.

The rite took place two days later, at the intersection of two paths in mafen, the sacred forest of the lower part of the royal compound. Members of bandansi, including a high ranking royal retainer, oversaw the rite, quietly instructing the four participants in turn how they should wash their face, forearms, and feet in “cooked” raffia wine (nâ ndu). Each of the four participants then handed some money into the palm of the royal retainer and made a speech of around three minutes.
imately twenty-five bystanders, most of them women, looked on (see fig. 11, chap. 4).

All participants and onlookers then returned to the palace and stood around the edge of the palace living and reception room. The four participants addressed the mfen, who was sitting on a leopard skin on the sofa, with a few words. The mfen then gave a brief speech about the necessity of living in peace together. The crowd applauded, and the mfen ended the event with the announcement “a mî” (it is finished).

The mfen and bandansi become involved in cases of reproductive illness most often when the participants have previously pursued a long and complex but unsuccessful therapeutic itinerary. The longer an affliction remains uncured despite the intervention of health-care specialists, the more likely the case will be transformed into a legal dispute involving accusations and counteraccusations of kin. Only then do “legal” experts become health-care providers.

Among all disorders, infertility is most likely to remain uncured; its cure is most likely to cross outsiders’ conceptual categories of medical, religious, and legal remedies. Therapeutic efficacy, defined in biomedical terms as the elimination of disease and in sociological terms as the termination of the sick role (Csordas and Kleinman 1996:9), is rarely achieved by any form of health care in cases of infertility in Bangangté. A successful outcome in these terms is even more unlikely for sufferers from the fear of infertility. Bangangté women who fear attacks to their reproductive capacity are most concerned with diagnosis, with finding the many layers of the causes of their affliction, causes both physical and social. For them, diagnosis is an important part of the healing process, as it guides women in understanding and responding to crises in their bodies and in their social relations. They often seek their remedies-cum-diagnoses from a broad range of health-care institutions, each potentially uncovering a different layer of the causes of reproductive threats.

Contending Approaches to Healing Reproductive Disorders

In seeking to uncover the causes of affliction and to cure reproductive disorders, Bangangté recognize distinctive premises and areas of competence for biomedical and indigenous care-giving institutions. The varying ideologies and specialties of health-care institutions in Bangangté communicate different messages about the nature of infertility and the ways reproductive health and illness are connected to or divorced from their social context. The organization of space, personnel, and practitioner–patient interaction in biomedical and indigenous health-care institutions further
contributes to what counts as “authoritative knowledge” in assessing reproductive threat (Jordan 1993; Sargent and Davis-Floyd 1997).

Bangangté patients seek out biomedical institutions to treat the specific, visible symptoms of illness and immediate, acute conditions. They consult biomedical practitioners to obtain injections or prescriptions for antibiotics and other manufactured drugs they hope will cure or diminish symptoms of pain, hypertension, accident, or infection. They seek biomedical treatment for such well-known conditions as malaria or wounds involving loss of blood, and for childbirth, which they understand as the “simple” part of procreation. In addition, patients view surgery as the undisputed monopoly of biomedical practitioners. Bangangté women consult biomedical physicians and nurses for prenatal consultations, physical complications of pregnancy, and delivery. They also seek relief of pelvic pain, radiographic diagnosis to “see blocked tubes,” and occasionally surgical intervention to correct anatomical causes of infertility. In the limited purposes they attribute to biomedical care, women respond to biomedical definitions of reproductive illness as caused by germs and mechanical failures of reproductive anatomy, and to biomedical definitions of the role of therapy as the elimination of organic disorder.

Biomedical practitioners believe they are treating causes as well as symptoms of concrete organic conditions. Biomedical personnel of varying rank and experience identify specific infections (bacterial, viral, or parasitic) and physiological processes or conditions as the ultimate cause of illness. They understand their task and special skill as diagnosing these infectious and physiological causes and prescribing or performing treatments that eliminate them and thereby cure the condition. They view their clients’ interpretation of social and mystical causes as superstitious ignorance. Most biomedical practitioners rarely explain their own diagnosis of illness etiology to patients. Several stated that explaining their diagnoses is harmful both to treatment and to their own position as medical expert. This systematic lack of communication supports the beliefs of Bangangté patients that successful biomedical treatment of symptoms is not a complete cure of their afflictions.

By contrast, practitioners of indigenous medicine claim to address the ultimate causes of affliction. Most Bangangté believe that specific afflictions are caused by the presence of evil in human relations and are the consequence of human and supernatural action. The anger of ancestors or the spells and fetishes of living evildoers “seize” and therefore become “attached to” the afflicted, causing illness, sterility, and other forms of misfortune. A number of indigenous healing procedures “detach” the patient from the bad influence ultimately causing the affliction. Mfen Meshinke’ and Nana, two elderly healers, both use water with herbs float-
ing in it to “wash” patients suffering from the ill wishes of others. This washing rinses away the bad feeling or spell, and thus opens or frees the patient to receive further treatment or to conceive. Felix, Paulette’s younger and more syncretistic healer, ties and unties of tiny bundles of grasses, feathers, and black thread to “detach” his patients from others’ spells. Performing rites of protection, Felix also ties a bundle of grasses and feathers to “attach” his spell of mystical armor, thus reversing the “detaching” necessary to begin healing. In the case of the disputing family, the bandansi had the litigants “wash” away their bad feeling. At the same time, the use of “cooked” raffia wine sealed or “attached” to their persons the participants’ oaths of good intentions, creating the conditions that would allow the young women to once again bear children. The implicit message communicated to patients is that the anatomical changes evident in reproductive illness (e.g., blocked tubes or amenorrhea) result ultimately from disturbed relations with one’s fellow beings. Only reestablishing tranquillity with the living, the ancestors, and the unseen will effect a lasting cure and the good fortune of fertility.

Not only the ideologies and specializations of health-care institutions, but also the organization of space and personnel affects practitioners’ interactions with women and their escorts. Space and functional differentiation in health-care institutions communicate messages about what and whose knowledge counts regarding the cause and cure of reproductive illness.

The locus of caregiving in different institutions affects the patient’s experience of social distance from the physician, nurse, or healer. Hospital patients wait in long lines in outside corridors, if they are lucky on benches. The patients of indigenous practitioners also wait separated from the healing scene, on benches or stools along the edges of the compound courtyard. In all settings, high status patients rarely need to wait in line. Only the healer or physician determines how soon a patient is to be examined and treated. Waiting patients are passive; the physician or healer is the powerful actor in this interaction dyad, and patients fear that upsetting the potential caregiver may prevent the desired cure. Social distance is dramatized by the symbolic use of space and rank in all healing institutions, but in different ways and with different effects for interaction style. Later we examine several examples of health-care providers in and around Bangangté, representing a continuum of styles and innovations between what most Bangangté informants identify as “modern” and “indigenous” medicine.

Biomedical Institutions. Biomedical hospitals in the Bangangté area are hierarchically organized, reflected in the division of hospital buildings into pavilions by types of illness and function (e.g., a reception and walk-in clinic
area, internal medicine, pediatrics, maternity ward, isolation ward for tubercular patients), arranged around a central courtyard. The two most imposing buildings, at both Bangangté Divisional Hospital and Bangwa Protestant Hospital, are those for administration and for surgery. Each member of the hospital staff has an assigned place within one of the pavilions, and an assigned rank within each functional unit of the hospital. Within each pavilion, ranked differentiation among staff members is expressed not only in the activities they are assigned but also in the space in which they may move. Nurses and occasionally nurses’ aides often have desks and tables with medical equipment around which their healing activities center. Orderlies at most have chairs where they may sit; they must usually walk around from patient to patient or from the pavilion to water source.

Smaller biomedical clinics, usually under the administration of one of these two hospitals, are less differentiated both in the tasks assigned to different staff members and in spatial organization. The pavilions (wards) of the hospitals translate into corners of one-room buildings, or into small rooms off the largest central waiting room. An examination room with an examination table may double as a delivery room, and a room or separate one-room building for the few inpatients, mostly women waiting to give birth or recovering from birth.

Verbal communication between biomedical practitioners and their patients is minimal. Sometimes biomedical personnel share no common language with their patients, and lower level staff or the patients’ escorts must be used as interpreters. Often nearly half the consultation time is used to fill out the register (Hours 1985:22). Part of the brief remaining time that physician or nurse and patient have together is taken up by a silent physical examination. Biomedical practitioners inform their patients of their diagnosis and recommended treatment in the form of authoritarian pronouncements with little or no explanation. Biomedical practitioners sometimes merely scribble a prescription in the patient’s health booklet and send the patient away without a word. Some regret having to do this, excusing themselves with the time pressure they are under to see as many patients as possible and with their lack of local language competence. Other biomedical practitioners, especially nurses, express dismay at the thought of explaining a medical diagnosis to a patient. They claim the patient would not understand, would worry unnecessarily, or would use the diagnosis to seek care from someone else (e.g., to self-medicate with prescription drugs or herbs bought at market).

This biomedical interaction style reflects organizational hierarchies, material constraints, and, perhaps, the role of competition in a highly pluralistic medical setting. No staff member will answer a question or perform a service for a patient if they believe the task falls in another staff member’s
sphere of responsibility and competence. These sharp delineations of spheres of therapeutic action protect biomedical personnel from accusations of incompetence, and help to limit the demands made upon their time and material resources. In addition, resistance to revealing the diagnoses may reflect practitioners’ fears of losing clientele. Information would free their patient from dependence upon the practitioner, allowing her to go with the diagnosis to another, competing practitioner, whether biomedical or indigenous.

Bangangté patients I observed present their problems to biomedical caregivers in a way diverging greatly from the stories of familial relations and “spirits” described by Debarge in the 1930s. Fifty years later, patients presented detailed descriptions of symptoms without superfluous commentary. They described pain and recalled the date of their last menstrual period with almost unbelievable exactness. Patients occasionally proposed a diagnosis; physicians and nurses made clear their annoyance at this short-circuiting of their competence and authority.

Felix’s Practice: A Creolized Medical Style.  The spatial organization of healer Felix’s healing compound and practice is an example of the present-day possibilities in a continuum between biomedical and indigenous practice and the impossibility of identifying which forms of practice and organization are truly “traditional” and when new forms emerged. Felix actively combines the symbols and practices of several healing traditions in a vibrant example of what Hannerz has termed “cultural creolization” (1987). Felix understands himself as a traditional healer, a ngakà who combines knowledge of herbs with divination and dramatic ritual to cure or protect his patients from the evil machinations of their enemies. His practice is in between indigenous and biomedical forms in terms of its organization as a business (he more than other indigenous healers is paid in advance) and its spatial and hierarchical organization as a “hospital” compound.

Felix’s healing compound is one kilometer distant from his residential compound, like that of physicians but unlike the compounds of other indigenous practitioners. Felix imitates the pavilions and largely functional spatial distinctions of the hospital, including a separate “pharmacy” building where herbs are dried and mixed by his apprentices. The hierarchical relationship among healer and various apprentices, expressed also in the location of their major activities within the healing compound (Felix in his consultation hut, certain apprentices in the pavilions, others in the pharmacy), parallels on a small scale that found in biomedical hospitals and clinics.

Felix combines these “modern” elements of spatial and staff organi-
zation with signs of self-conscious traditionalism: the bush location of his healing compound, the herb garden in back of his consultation hut, and a low, dark and mysterious-looking consultation hut (of “traditional,” i.e., palmfrond-spine and thatched-roof construction) mixing a sense of the mystery and power of an indigenous healer’s sacred grove and the organization of a biomedical physician’s office. The objects within Felix’s consultation hut also combine signs of modernism (a stack of health booklets, an X-ray photograph stuck into a space in the palm-spine wall) with rattles, horns, herb-filled calabashes, feathers, and a “tree of peace.” Felix’s practice appeals particularly to Bangangté’s more educated elite and to younger Bangangté patients. Both groups of clients are concerned with the cultural authenticity of things “black” and the supposed reliability of things “white.”

Felix’s practice combines the health booklets (carnets), prescription writing, and rubber stamps of biomedical institutions with the dramatic seances, diagnostic divination, and ceremonies of the attachment and detachment of spells known from indigenous practices. He has set consultation hours, seeing patients one after another, referring them to his “pharmacist” or asking them to wait or return for divination and healing requiring the presence of kin. When Felix treats patients for infertility, he uses the “biomedical” vocabulary of blocked fallopian tubes rather than speaking more generally about blocked passages and bad water, as do other healers. In his negotiation of ethnogynecological reality, however, these fallopian tubes are often blocked not by infection and scar tissue but by the nefarious activities of mean-spirited kin. Thus, he focused Paulette’s anxieties about her social position in the royal compound upon the alleged havoc her cowives could wreak upon her ability to conceive.

**Nana’s Practice: Healing as a Family Enterprise.** Unlike the young and flamboyant Felix, Nana in 1986 was an elderly, modest man who has since passed away. Also a ngakà, or healer performing both herbal treatments and divination, Nana received his patients in the living compound he shares with his five wives and numerous children. One of Nana’s wives or children led newly arrived patients and their escorts into the central courtyard of the compound, the space between the main living house, the kitchen for medicines, and the kitchen-houses of his wives. Nana most often consulted his patients in his medicine-kitchen, a bare mud-brick room with a fire in the middle and a number of low stools. Lacking the cooking pots of a woman’s kitchen, Nana’s medicine-kitchen instead contained some bottles and calabashes filled with ground, dried herbs, and a colored picture of Pope John Paul II. Objects evoking the power of royalty were displayed, but not protected from the playfulness of Nana’s children;
next to one wall a small wooden sculpture of a male noble wore a hat of an upside-down plastic bag. The kitchen’s hearth was used to “cook [herbal] medicines” (nâ fu), often ground by one of the younger wives or occasionally by one of Nana’s sons serving as apprentice.

Nana listened to his patients’ illness narratives in the medicine-kitchen, eliciting information through a parlay of questions and answers among himself, the patient, and her escort. Occasionally one of the healer’s sons or daughters, acting as informal apprentices, would be present at these consultations. After a nod from healer Nana, the patient introduced the question-answer period with a brief narrative of symptoms or disturbing events that led the patient to seek the healer’s help. These narratives usually left out visits to other healers but included visits to hospitals. Some consultations then ended when Nana gave the patient some ground herbs wrapped in a scrap of paper and described how to take the herbs and when to come back for the next consultation. The patient then paid Nana in cash for his services, a voluntary amount without discussion. Nana claimed he would argue and ask for more if dissatisfied.

Nana performed hands-on healing practices in a small enclosure surrounded by palm-frond screens at the rear of the entire compound. He referred to the enclosure as a sacred grove, a place of privacy and imbued with spiritual power, similar to sacrifice spots under large trees in the “below” of the royal compound. Within this enclosure, Nana washed his patients in an herbal bath, massaged arms, legs, or abdomen, and drew poisons or objects out of the body. For women complaining of infertility, Nana drew a blood clot, hair, or small pebble out of his patient’s vagina. Nana accompanied this action with an explanation of how the woman’s fertility was “blocked” by an ill-wisher, and that now at least part of the blockage was removed. Nana’s patients were passive, submitting silently to his procedures and initiating no actions themselves. The following case illustrates the interaction between Nana, an infertility patient, and her escorts in a single therapeutic encounter.

A Case of Infertility and Marital Strife

Miteu, a 21-year-old woman, had been married three years but had never been pregnant. She lived in Douala and came to Nana accompanied by her sister and their paternal aunt. The two sisters were orphans and claimed that their father’s sister could guide them and keep them from being fooled by charlatans. Nana nodded at this acknowledgment of the aunt’s trust in his authenticity.

Before Miteu was married, her husband had proposed to another woman and then changed his mind. Miteu suspected that her husband’s
former fiancée had paid a sorcerer to put poison in her belly, preventing her from conceiving. Miteu had been to the hospital in Douala. There the doctors had asked to treat her and her husband simultaneously. Miteu’s husband refused, and he also refused to pay for his wife’s treatment. Instead, he took a Bamiléké woman from the provincial capital of Bafoussam as a lover and made her pregnant. Miteu said her husband wanted to marry the Bafoussam woman “and chase me from the house first.” Miteu was not sure if she wanted to return to her husband. What she wanted most from Nana was to have a baby to make her life “complete” and to leave someone after her so that she would not “disappear from this earth.”

Nana led Miteu to his enclosure, where she undressed. Nana washed her in an herbal bath, groped around Miteu’s crotch, and “removed” a wad of black pubic hair surrounding a tiny piece of bright red plastic. Nana said this was the “poison” that someone had put in her to keep her from getting pregnant. He then took a razor blade and made seven small incisions on Miteu’s belly, which he then painted with an herbal mixture. The consultation ended in the medicine-kitchen, where Nana prepared an herbal mixture for Miteu to take home. Miteu’s paternal aunt paid him 2,600 CFA francs (about $5.00 U.S. in 1986), wordlessly.

Miteu found herself in Nana’s vicinity and in the supportive company of her sister and aunt because all three were caring for yet another relative at Bangangté Provincial Hospital. Nana’s healing compound was only a ten-minute walk from the hospital, and Nana was well-known among the hospital patients and the scores of kin who cared for them, cooking meals, washing clothes, and fetching medicines. Miteu and her kin encountered a familiar form of therapy and interaction with the healer at Nana’s compound. Despite differences in specializations, most indigenous practitioners treat cases of infertility and suspected attack to reproductive capacity in a strikingly similar fashion.

Similar to biomedical practitioners, indigenous healers like Nana mainly pronounce their diagnosis (or even merely the necessary treatment) in an authoritarian manner with little or no explanation of the cause or progression of the affliction. Treatment for infertility, however, almost always requires more explanation than herbal treatment for a “simple” illness. Women consulting a ngakà assume an element of “custom” in their reproductive afflictions. Diagnosis is part of the treatment; it goes beyond the naming of a particular disease to identify the cause of the patient’s troubles in wrongdoing, ancestral wrath, or witchcraft. The ngakà usually expresses this diagnosis in vague enough terms that it is likely to be further interpreted by the patient and her escorts in such a way that it fits a partic-
ular situation, applying his knowledge of stereotypical social conflicts to the information contained in the patient’s opening narrative.

Healers like Nana run their practices like a family enterprise. The consultation space is located within the healers’ residential compounds, little differentiated from other areas of the compound. The differentiation of tasks among the healers’ helpers is the same differentiation that occurs between family members. The medicine-kitchens, the central location of consultation, are visible monuments to these healers’ emphasis on and skill with herbal medicines. Despite the familiarity of the household compound, both the doctor’s office and the healer’s medicine-kitchen are rather mysterious to the patient; who knows what power lies in the various medicine-filled vials and equipment displayed on white tables in the hospital and along the walls on the floor of the medicine-kitchen. The doctor’s office, however, is even more mysterious, having no similarity to the patient’s own home or kitchen. A large desk, covered with papers and books the patient cannot read, separates patient and doctor during most of the consultation. By contrast, both healer and patient squat on low stools around the medicine-kitchen’s hearth, beginning the consultation with involved narratives about the social background to the sufferer’s affliction.

Despite an emphasis on social relations and ancestral sanction in the causes of infertility, indigenous healers increasingly treat isolated illness episodes of individual clients. This tendency parallels recent transformations in social and family organization and economic realities. As Bangangté more frequently choose their own marriage partners and/or migrate far from their home villages, extended kin ties become loosened. This tendency toward narrower group ties and nuclear families finds its extreme among the rural poor, especially among those wives of absent labor migrants who can no longer participate in informal economic exchange networks. These women, relatively socially isolated, have fewer people to offer them social and material support in the event of an illness crisis. Likewise, the healer of such a woman is less likely to draw her already few social relations into therapeutic procedures.

Space, Secrecy, and Therapeutic Choice in Infertility Treatment. The consultation areas of biomedical and indigenous practitioners dramatize differences in caregiver/patient competence and thus help shape interaction during the consultation. Expectations of what is relevant to various kinds of practitioners shape the way patients present their afflictions. Because infertility patients seek to uncover different layers of the sources of their afflictions by consulting multiple kinds of health-care providers, therapeutic choice is not wholly guided by the typing and pairing of afflictions and heal-
ers. In addition, choice of therapy for reproductive disorders is rarely discussed openly among an extended therapy management group. Instead, a woman’s wish for discretion powerfully shapes the timing and locale of her quest for therapy. The location of different types of health-care institutions affects the degree to which a patient can fulfill her wish to keep her quest for a cure secret. The bush or neighborhood location of most indigenous practitioners allows a patient to visit this specialist more or less discreetly. A visit to the hospital or clinic is, by contrast, much more public. It requires an appearance in the town or village center or waiting time at the taxi park if the patient is to travel to the mission hospital 15 kilometers away.

Discretion is especially important to women seeking cures for reproductive difficulties. They do not wish to publicize the shame of infertility. They may suspect the very people from their potential support networks of threatening their reproductive potential. Thus, unlike with other health problems, they often try to keep their search for health care secret from potential escorts and other supporters. This discretion is almost impossible to maintain if the afflicted woman visits a biomedical hospital or clinic. In addition to women’s assumptions about biomedical lack of competence in matters of infertility, the public nature of visits to biomedical institutions contributes to their almost total avoidance by women for all reproductive matters excluding prenatal and delivery care.

The separation of obstetric care and the treatment of infertility is an interesting case of patients and healers defining areas of expertise and utilizing biomedical and indigenous care for different aspects of reproductive health. Indigenous healers treat problems of infertility, believed by most Bangangté to be illnesses of custom (ndon) and thus improperly understood by biomedical practitioners. Nonetheless, Bangangté women go to these “unseeing” biomedical specialists and not to indigenous practitioners when they give birth. Some women vaguely mentioned getting charms to ease birth from healers. Their reference to childbirth “medicines” as “those little things” may have been women’s attempt to limit information about their most private visits to healers. On the other hand, the analysis of Bangangté women’s fears regarding reproductive processes in the preceding chapter indicates that while the stages of conception and gestation are full of dangers that could be mitigated by an indigenous practitioner, childbirth itself is threatened by custom only if the woman has committed adultery. Women’s concerns regarding childbirth therefore address problems they feel are best treated by biomedical institutions: pain, loss of blood, and infection.

All of the Bangangté women who reported receiving childbirth medicines insist that they always go either to hospital or clinic for delivery. As early as 1937 Egerton noted the gradual disappearance of traditional mid-
wifery in Bangangté (1938:236). He and current commentators on Bangangté health care (ranging from patients to biomedical personnel) attribute the decline of traditional midwifery to the high density of biomedical facilities in Bangangté and its surroundings.

Visits to new mothers who have just given birth provide women the opportunity to become familiar with biomedical obstetric facilities, equipment, and procedures. While all visitors comment on the baby’s size, skin color, and hair (the more the better), much of the conversation focuses on the creams, powders, linens, and baby clothes the mother has brought to the hospital. Visitors also ask the mother about biomedical neonatal care, and the mother is proud to demonstrate her new knowledge. In this way, a woman’s social network provides her with sources of information on which to base her own decisions regarding indigenous and biomedical gynecological and obstetric care.

**Therapeutic Choice and the Rhetoric of Affliction**

When a Bangangté woman fears some disturbance of her reproductive health, she now has a wide array of health-care institutions from which she can seek cures. When health planners discuss therapeutic choice, they emphasize traditional–modern differences in specialization on particular afflictions, distance, and shared beliefs between caregiver and patient. Bangangté women tend to delineate reproductive problems as a domain for indigenous healers, and medical care of childbirth as the responsibility of biomedical institutions.

But Bangangté women do not manage their reproductive health crises as isolated individuals. In choosing health care they are affected by the kind of social and material support they can expect from others, their knowledge of health-care alternatives, and the social dynamics of their therapeutic management group (the fluid association of kin and acquaintances who help decide about the choice, timing, and allocation of resources to her therapy [Janzen 1978a, 1987]).

In the next chapter we will explore the ways the rhetoric of reproductive affliction is a symbolic resource in negotiations over gender relations and cultural identity. Here I view therapeutic choice as a symbolic resource. Patients and their therapy management groups negotiate who has social control over reproductive behavior and ideological control over values through the way they define an unexpected timing and number of pregnancies. But patients and their therapy management groups choose therapies within the constraints of broader social and economic conditions. Women fearing infertility or seeking reproductive health care bring differing resources of knowledge and wealth to their quest for therapy.
Some Bangangté women have the knowledge and resources to patronize the most renowned healer and simultaneously receive treatment in a private room at the Protestant Hospital in Bangwa. Other women only have the resources to consult a single institution, know of only few alternatives, or cannot afford to bring any single therapy sequence to conclusion. Such differences in access to health care contribute to divergent qualities of women’s fear of infertility and their ways to deal with this fear.

While the anthropological literature on therapeutic choice addresses these issues, it tends to concentrate on a series of single variables in developing hypotheses regarding the social relations of care seeking. These variables include: shared illness beliefs, support networks, kinship and jural or moral responsibility, the duration of the health crisis, material resources, and forms of face-to-face interaction between caregivers and their clients. I examine each of these variables in the light of how Bangangté women seek care and cures for their reproductive difficulties. These variables interact in a field shaped by the history and political economy not only of health care in Bangangté, but also of relations between men and women, nobles and commoners, and the local polity and the state.

Beliefs. One body of the medical anthropology literature finds the most salient determinant of therapeutic choice to be that patient (or patient and kin) and health care giver hold common beliefs or assumptions regarding health and illness. This approach emphasizing the cultural or meaning aspects of therapeutic choice is applied by Sargent (1982) in her study of obstetrical care choices among the Bariba of Benin and is at the center of the early work of Kleinman (1980) on explanatory models and caregiver/patient interaction in the medically pluralistic setting of contemporary Taiwan.

When Bangangté talk about the past, particularly the early years of Protestant evangelization and medical care, they describe clear lines of choice based on belief for certain segments of the Bangangté population. Members of the royal family followed the mfen’s wishes and completely rejected the Christian missionaries and their healing. They sought cures for their afflictions from those indigenous healers whose healing powers were closely tied to notions of royalty and its magical strength. The early converts, largely descendants of slaves and members of other groups marginal to royal power, were zealous in their rejection of all witchcraft and magic. They strictly sought care only in biomedical institutions where the model of illness causation, including germs and God but excluding the malevolent actions of others, fit with the sermons of their religious leaders. This strict rejection of certain types of health care is one way to simplify the field of choice. With changes both in the royal compound and the ser-
mons of the missionaries, such clear distinctions of religious belonging, shared medical ideologies, and therapeutic choice no longer exist.

In Bangangté of the 1980s, few people chose their health care primarily because they shared the same model of illness and healing with their caregiver. Some beliefs, general ideas about reproductive processes and the sources of their evil disturbances, were learned over a long time and were explicitly Bangangté. In this sense, most Bangangté women shared the kitchen and cooking metaphors of reproductive processes with nearly all indigenous healers. Indigenous practitioners used elaborations of these ideas both for their own healing and when they wish to refer a patient to a biomedical institution. When mfen Meshinke’ of Bantoum diagnoses a woman’s reproductive difficulties as the presence of *ntse kebwo* (bad water), the patient can understand his explanation in terms of her notions of the need for proper, unspoiled ingredients in her reproductive cooking. But mfen Meshinke’ often refers such patients to the hospital to have this bad water removed. The biomedical practitioner does not share the healer’s or patient’s beliefs regarding procreative ingredients. He may nonetheless perform a dilation and curettage, a procedure that the patient thinks is cleaning the bad water away. Patient and caregivers thus approach this procedure with completely different assumptions about the causes of reproductive disturbances.

Most young Bangangté women consult biomedical practitioners during their pregnancy, in the framework of regular prenatal consultations, although their main concerns during pregnancy involve problems of custom that are out of the range of the physician’s or nurse’s competence. Women feel that certain practitioners can best perform specific caring or curing tasks, regardless of their understanding of what the woman believes is going on in her body or in the social relations that can affect her health.

More importantly, a patient’s beliefs and knowledge regarding health, illness, and reproduction are not set and unchanging, but at the time of crisis are further formed in interaction with the health care giver and with others who become involved in the care-seeking process. Some of what appears to be new knowledge formed during the healing encounter may be impression management on the part of patients, going along with a healer’s diagnosis but not believing it. However, Paulette’s case in chapter 1 demonstrates how her “knowledge” regarding her affliction, its causes, and the sources of illness in general developed in the dialogue between her first fears and selectivities and the information she received from Felix’s diagnoses during her series of visits.

In addition, seeking cure involves not only the suffering woman, but also her social relations, people who act as brokers, helping her learn
about health-care alternatives and choose among them. These people act as go-betweens, forming preliminary diagnoses, making appointments for the patient, and escorting her to various health-care institutions (Boswell 1969). Thus, it is not only the patient’s illness beliefs that must be taken into account in choosing therapies, but also those of her support network.

Support Networks. Janzen (1978a) suggests that most patients in Africa take a passive sick role, and that the timing, arrangements, and choice of consultations among multiple alternative forms of health care are managed by those in the patient’s social network. This network forms the basis for the more or less temporary therapy management group. Group dynamics within this therapy management group determine whose suggestions will prevail in actual therapeutic choice and timing.

Bangangté refer to the opinion leader in a therapy management group as a person whose voice has “weight.” For Paulette, her cowife “mother” Claude had the “heaviest” voice since she was the only person whom Paulette knew in Bangangté who expressed an interest in her problem. The other Bangangté women I knew perceived the sporadic advice they received on reproductive and medical treatment according to the “weight” of their interlocutor’s voice. Since therapy management in Bangangté operates as disjointed conversations among a dispersed network of people with varying relations to the care seeker and to each other, it is difficult to actually observe group dynamics within therapy management groups. These groups rarely meet all together unless the case goes into the realm of customary law. In addition, Bangangté women are very secretive about their search for cures when they are still involved in a health crisis.

Bangangté materials indicate that women in different positions have support networks of different extent and reliability. The ability to reciprocate at a later time is important in encouraging help from others at a time of need. Thus, geographical proximity and some degree or combination of prestige and/or material resources help gain support from more people. Almost no one in contemporary Cameroon has the means to care for themselves in the event of a health emergency. Maintaining social ties through affection and exchange is the best “investment” or “insurance” should misfortune require a person to consult one or many health-care specialists. The poorest women, whose social ties loosen because they cannot fully participate in informal gift exchange networks, have a more limited pool of kin and acquaintances from which they can receive advice and aid when illness strikes or when they fail to bring living children into the community. Women who live far from the households in which they grew up are relatively geographically isolated from their pam nto’ relations,
those with whom they have established close ties of affection and on whom they can most certainly depend for aid.

In many cases of illness, a woman’s cowives are closest to her and most available to help.

When you are two [wives] in the house, if you are ever ill she [the co-wife] can fetch you a little water before she even goes to tell your husband that you are ill. (Bwoda’, an elderly woman of Bantoum)

I like polygyny. Even my mothers numbered twelve in their compound. It is good because if I fall ill, one of my cowives must give me water or even bathe me, another will prepare food for our husband so he won’t starve during my illness. (So’nju, aged ca. 60, Batela’)

To be in polygyny is good. For example, you can be sick and it is your cowife who helps you. In a monogamous marriage you are only part of a pair with your husband. If you fall ill and your husband falls ill, who will give you water to drink? That’s what it is. If your husband works [for wages], he can’t leave his work because you are ill. It is even thanks to this job that he can buy the products [medicines] they will prescribe for you at the hospital. And to leave you like that without caring for you, it’s bad. A cowife could take care of you. (Ncanko, aged 28, Batela’)

Nonetheless, Bangangté women rarely turn to their cowives in seeking cures for reproductive illness. Cowives might help with food preparation or childcare if one is bedridden or absent. Reproductive difficulties rarely render a woman bedridden and dependent upon this aspect of her cowives’ help. They may also fear that their cowives have caused their reproductive illness.

Me. I tell myself that a woman who lives alone doesn’t profit from it. I think that when you are two or three, that’s good. And even if it’s good, there is a ‘but’. It’s that if you are sick, the other could fetch water, for example. But when there is no understanding between you, it becomes difficult. It’s the big misfortune that has already come to earth. (Kokwa, older than 73, Bantoum)

I have lost one child. And I then had problems to have a second child. Because I was in a polygynous household, there were too many problems. I was sometimes told that it [the reproductive difficulties] is because of my cowives. (Jacobine, aged 23, divorced, Bantoum)
Because most women at one time or another suspect their cowives of evil machinations threatening their reproductive health, they rarely inform their cowives of their difficulties or ask them for advice and support.

**Kinship and Jural Responsibility.** In contrast to cowives, it is kin and those who have jural responsibility for the patient from whom Bangangté expect help in case of reproductive difficulties. Bangangté women may suspect certain categories of kin of being implicated in the cause of their reproductive affliction, for example a foster parent (tuteur) or an errant husband. But those same and other kin may also try to insure the afflicted woman’s reproductive success, out of interest in adding to their matriline or patriline or out of affection and solidarity with the woman. The composition of women’s therapy management groups (Feierman 1985; Janzen 1978a, 1987) reflects the multiple forms of jural and affective ties in Bangangté kinship. Not all members of these often fluid groups have the same amount of interest, responsibility, and authority in relation to the patient and to the other members of the group.

Different members of Bangangté therapy management groups have diverging amounts of influence and authority within the group. Bangangté refer to their power to convince others and to determine the course of action as the “weight of their voice,” an expression also used to describe degrees of “complicatedness” with reference to political and economic power and witchcraft. Being “complicated” may give someone power, but differs from moral and jural authority.

Bangangté recognize differences in group members’ moral and jural responsibility toward the afflicted person. In contrast to cowives and neighbors, Bangangté feel that both agnatic and uterine (pam nto’) kin are the most reliable supporters in case of reproductive illness. Bangangté often call on agnatic kin, and particularly the father or his heir, in the context of jural responsibility. Husbands, and sometimes their agnatic kin, are thought to be jurally responsible for the well-being and care of their wives and children, but this responsibility is most often expressed in terms of complaints when not fulfilled. Miteu, who consulted healer Nana for infertility, accused her husband not only of neglect but also of involvement in causing her reproductive failure.

While Bangangté believe that agnatic kin and husbands hold jural responsibility for the afflicted, pam nto’ kin hold moral responsibility. Women often seek recommendations about indigenous and biomedical healing specialists from their maternal kin. Jeanne, a wife of the mfen, traveled to her maternal family in the three hours distant kingdom of Bapi to receive her mother’s advice on fertility enhancement medicines. The trust she had in her mother’s advice and the discretion she could expect in...
this sensitive subject of fertility outweighed the cost and inconvenience travel posed to Jeanne.

The use of kinship ties and the jural responsibility of certain categories of kin within Bangangté therapy management groups varies according to the afflicted woman’s social position. When a woman has become estranged from her kin, as in Paulette’s case, the jural responsibility of agnatic kin and even the moral responsibility of pam nto’ relations may no longer count. In addition, members of a therapy management group may not be able to give the support required by their responsibilities, either because their position within the group is too weak to influence decision making or because they do not have the knowledge or material means to truly help the patient. These distinctions refine our view of social differentiation among those who surround, support, and/or impede a sick or infertile woman’s efforts at cure and solace.

Duration of the Health Crisis. In addition to social relations among members of a therapy management group and between them and the patient, the duration of the health crisis affects the choice and range of explanations and therapies they attempt. Referring to his Tanzanian data, Feierman (1981) points out that the longer a crisis lasts, the more people become involved in therapy management. Through this process, the group either grows in size, which changes group dynamics, or some members drop out while new ones become involved in the case.

In Bangangté, fertility problems are particularly long-lasting, and thus often require long-term and broad support networks. Because these problems are of such long duration, women may have a difficult time gaining or retaining support when seeking cures for reproductive difficulties. In addition, reproductive difficulties almost never appear as a crisis requiring immediate care. A woman’s complaint about childlessness may not awaken potential supporters’ sense of urgency. De facto female heads of households, women whose husbands are absent due to wage labor migration, often have a smaller pool from which to draw supporters in times of crisis (Feierman 1981). For a health crisis of long duration, this may put such women at particular risk. Isolated women like Paulette have an even harder time mustering cure-seeking support for their long-lasting and rather unclear misfortunes. Thus, as Inhorn points out for infertile Egyptian women, therapy management groups tend to collapse over time for poor, infertile women. Nonetheless, many women continue their lonely search for cure and explanation, consulting healer after healer, doctor after doctor.

Material Resources. As with the demographic literature on reproductive decision making, the public health literature on health-care access and
choice assumes that patients analyze the divergent costs and benefits of indigenous and biomedical treatment when seeking cures (Bannerman 1982). The anthropological literature on therapeutic choice also refers to costs and benefits, but includes social as well as strictly material calculations. For example, Boswell (1969) analyzes the social costs and benefits of associating with certain escorts. Mullings (1984) discusses how a lineage head will direct a patient to a health-care institution that supports his own view of social relations and his interests in maintaining his position vis-à-vis the other members of the therapy management group.

In Bangangté, the mode of payment, costs, and the certainty of the fee for service in different types of health-care institutions affect Bangangté women’s access to and choice of various curing alternatives. Consultations at the public hospital were free in the 1980s, but costs of attending this institution were incalculable because patients must buy their drugs at what was then the only private pharmacy in Bangangté. (In the 1990s, fees were introduced in public health institutions, and two private pharmacies were in business in Bangangté.) In contrast, both consultations and the filling of prescriptions at Bangwa Protestant Hospital were made on a fixed-fee basis. The costs of indigenous healers were less calculable for patients and often ended up being higher than those of either hospital. At hospitals and clinics, however, payment was always in cash. For some patients it was easier to consult a healer who might eventually demand higher payment, but who could be paid in kind.

Patients and therapy management group members must also calculate the cost in time that visits to various institutions entail. Visiting the healer is sometimes more costly in time because healers are frequently absent from their compounds. Their treatments also generally require many visits. Patients have long waits at whatever type of institution they choose, although the wait is always less for very prominent patrons. Distance and transportation are among the most important cost factors considered by Bangangté patients. Getting to and from the caregiver is figured into the cash outlay, as is the debt of a personal favor should one receive a ride from an acquaintance. Distance and the available modes of transportation to various institutions are also part of Bangangté patients’ time calculations when they choose between different forms of care. The experience of distance and transportation has changed considerably through time. Elderly Bangangté express that going to Bangwa hospital was very difficult in the past; “it did not exist for us.” Now, with paved roads and rather frequent bush taxi service, traveling the 15 kilometers from Bangangté town is much easier, although it still requires cash.

Interaction Styles. Bangangté patients choose to consult different health-care institutions or particular practitioners within them according to their
perception of how they are treated by caregivers and their institutions. While they expect demonstration of superior knowledge and authority from caregivers, especially from biomedical staff, Bangangté prefer attending those institutions where they find solace and feel they are treated with dignity. Some biomedical physicians exhibit condescending mannerisms toward the “uneducated”; for patients who cannot express themselves well in French, this effectively denies them a needed sense of consolation. Those who admit having visited indigenous healers are often reprimanded and humiliated by biomedical practitioners. Patients with much experience or with knowledgeable escorts find the type of interaction they prefer by attending specific healers, the mission hospital (which has a good reputation for humanitarian treatment), or the local public or mission clinics where they know the staff personally and can use particular staff members as escorts. At Bangangté Divisional Hospital, patients often go directly to the pharmacist or a known pediatric nurse, or they wait in a long line in front of a particular physician’s office, rather than being served immediately by another physician perceived as less friendly. Jeanne, a young wife of the mfen, prefers to make the longer trip to the mission hospital in Bangwa rather than seeking care at the public hospital in Bangangté. As a mfen’s wife, Jeanne should receive free care and drugs at the provincial public hospital; she claims, however, that hospital personnel always dispute whether she is really a royal wife, which she finds humiliating.

A Bangangté woman’s social network is her most important source for learning about the different interaction styles of various health-care institutions. Such knowledge is crucial in women’s decision making regarding therapies for their reproductive problems. In addition, previous knowledge of interaction styles allows the patient to adjust her way of presenting symptoms according to her expectations of the warmth, communicativeness, and expertise of different health-care specialists.

Single-factor hypotheses attributing the process of therapy seeking to shared beliefs, to economic calculations, or even to the social dynamics of decision making over the definition of illness and choice of therapy, do not capture the complexity of social, cultural, and historical dynamics in plural health systems. Current conditions in Bangangté offer varieties of health care, but also confront women with a field of uncertainty in their ability to address fundamental problems of reproductive health.

Access to Care, the Therapeutic Process, and the Distribution of Fear

Over the past century, the already varied and dynamic field of health care expanded dramatically in Bangangté. New illnesses, including sterility-
producing sexually transmitted diseases, and such changes in social structure as the introduction of labor migration on a grand scale and the mfen’s loss of political autonomy during the colonial era led indigenous healers to seek new medicines and forms of healing. The continuing decline of royal power and the diversification of the hierarchies within which Bangangté could strive for personal advancement led to innovations and shifts within the field of indigenous medicine. Specialists whose healing activities were closely tied to concepts of royalty and its magical influence on health declined in importance for patients seeking cures. Healers who concentrated on herbal treatments of isolated disorders, whether caused by physical agents alone or through the activities of ancestors and witches, increased in importance. Many present-day healers have adapted to their current cash needs and require forms of payment barely distinguishable from those of biomedical institutions. They have become entrepreneurs, competing with other indigenous and biomedical institutions in the expanding field of Bangangté health care.

The growing kinds and numbers of health-care institutions in Bangangté give Bangangté women suffering from reproductive difficulties greater choice when they seek care and cure for their afflictions. This choice, however, does not exist equally for all women. The existence of certain forms of health care does not guarantee that all have access to these alternatives. Such access requires that a woman know of a particular institution, can get to it, and can pay for the treatment she hopes to receive. The few Bangangté women with significant cash incomes (civil servants, wives of civil servants, and successful entrepreneurs) can consult more types of health-care institutions more frequently than the majority of poor, rural cultivators. Among the group of poor rural women, significant differences exist in their ability to take advantage of health-care alternatives. Their social and material resources depend most on the size and reliability of their support networks, including cowives, neighbors, and agnatic, affinal, and maternal kin. Their choice of health-care alternatives depends on these resources as well as upon group dynamics within the woman’s support group, and the duration and apparent urgency of their illness. A woman whose limited social and material resources do not allow her to seek all the cures she needs feels truly vulnerable to reproductive threats. Should reproductive misfortune strike, she would be less able to deal with it than her wealthier neighbor.

When a woman seeks cures, she may try to manage differing aspects of her fear of reproductive threats. Her main concern may be with her physical infertility, and thus directly with her wish for a child or, in the case of secondary infertility, with additional children. Nonetheless, seeking cures may fulfill other functions for this woman. The process of seek-
ing cure may dramatize the woman’s social and medical plight to others. By becoming the center of a good story, even if her “infertility” is shown to be due to her own shortcomings (as in Paulette’s case), the woman may hope to gain social recognition (Bleek 1976). For a particularly poor woman, being ill and seeking cure may be a way of increasing social support. When she works on her tiny fields, she may never grow enough crops to allow her to pay for her children’s school fees. But when she falls ill, a number of cowives and neighbors may help her out to make this medically unrelated goal possible.

Finally, a woman may secretly consult a diviner to solve an inner conflict for herself (Shaw 1985). While she may keep the diviner’s diagnosis a secret, her fears about the social relations causing her difficulties will be given a concrete answer. The diviner’s opinion that her cowives are evil, or on the other hand that she has nothing to fear from them, allows her to adjust her interaction with her immediate social environment.

Bangangté women’s expressions about reproductive threats indicate that disturbances in their immediate social environment, and in the state of the kingdom as a whole, are as important as actually curing a state of infertility. Women talk about not being able to bear children, keep them alive, or keep them faithful to Bangangté traditions. Nonetheless, they often seem to seek explanations for their suffering instead of cures. Is this because cures cannot be reached? Or, is it because infertility is merely an idiom expressing other problems that confront rural Bangangté women? If so, does the idiom of infertility provide a vocabulary of affliction and explanation with which to understand these problems?