Family planning and tradition: a view from northern Cameroon

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Sometimes efforts to improve the quality of life can hasten the destruction of a whole way of life, in which case the “beneficiaries” can lose much more than they gain. This presents health workers and planners with difficult choices.

In the rural Kolofata district of northern Cameroon, as elsewhere in the non-industrialized world, it is unusual to find adults who are more interested in limiting than in increasing their offspring. Children are prized and recognized as a source of wealth, labour, income and insurance against the disabilities of old age. Children shepherd the goats and sheep, fetch water, tend market stalls, help with farming and chores, and care for younger siblings. As teenagers, girls are given in marriage for money, cattle and cloth. Boys bring home wives who gradually relieve aging mothers of the daily burdens of the household. The old retire gladly to mats under trees, occupying themselves with endless talk and gentle tasks. The more children one has, the greater the chance that more will survive, and the greater the chance that adequate prosperity will allow life to follow its expected, secure course.

Overpopulation is recognized as neither a current problem nor a threat. Periodic drought has resulted in short-term famine in some areas, but fertile land, much of it unfarmed, is abundant. Generous sources of surface and groundwater want only the technical apparatus and will to be harnessed. Housing is primitive but never unavailable. Cooking fuel is cheap. Orphaned or abandoned children left to roam the streets are non-existent. There are no gangs of aimless angry youth.

It is a poor area, undeveloped in terms of transport, communication, health or education. There are no paved roads, no telephones, no post office, no farm machinery, no industry. Due to the population’s lack of interest in education, only a tiny minority of children attend any of the thirteen public primary schools in the district. Adult illiteracy exceeds 90% and under-five mortality has been among the highest in Africa (1). People of half a dozen ethnic groups, each with its distinct

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language and culture, live in harmony. Three quarters are Moslem; the rest are Christian and animist. Life throughout is steeped in tradition, cultural taboos and sorcery. Modern methods of family planning are unknown, but traditional means of limiting population are plentiful.

**Traditional population control**

Some practices effectively promote infant mortality. Most women, for example, withhold breast milk from their newborn children for a minimum period of three days (2). The sticky consistency and yellowish colour of colostrum are considered unhealthy. A mother who dares to feed her child during this period will not be credited with providing possibly life-saving protection against enteric pathogens, but blamed for causing future illness and possibly death. Some women who have already buried one or two of their offspring believe that their milk is inherently and incurably bad. These women avoid breast-feeding altogether, instead giving their babies some combination of millet gruel, sugar water and animal milk or fat. News of the unique benefits of early breast-feeding and the devastating effects of inappropriate substitution is received with polite tolerance and profound disbelief.

Many traditional birth practices, in particular the use of unsterilized millet stalk to cut the cord, combined with a history of indifference or resistance to maternal vaccination, have contributed to the high incidence of neonatal tetanus and sepsis. This is complicated by the fact that in many families a neonate may not be removed from his home until he is named on the eighth day. In case of sickness, he cannot be taken to a health centre. Illness is treated in the home with herbs and abdominal scarification, and the compromised child’s intimate exposure to pathogenic organisms is thus compounded. Even after the eighth day, families are unlikely to be willing to devote much effort or expense to keep a sick infant alive. In traditional households, facial scarification is performed unsterilely on the eighth day, and later during infancy the uvula is excised similarly.

Seemingly innocuous daily activities in the lives of the newborn are replete with opportunities to contract illnesses which may lead to death. A mother shows affection by spitting in the face of her infant after breast-feeding. While being washed, babies are given their bathwater to drink. Close, unprotected exposure to dense smoke from cooking fires begins as soon as the mother first straps her newborn baby on her back. Spitting on the walls and floor in the confined quarters of a grass or mud hut is accepted practice, much increased in Moslem homes during the month-long yearly fast.

Conception itself is limited by a number of traditional practices, including breast-feeding which is continued for 18 to 24 months. Socially a stigma is attached to a couple who conceive before the youngest child is walking. Polygamy – widely practised among Moslems, Christians and animists alike – might also reduce the reproductivity of individual women.

Finally, the traditional strenuous discouragement of formal education, particularly for girls, helps to perpetuate high childhood mortality (3). Illiterate, submissive, ignorant and bound by superstition, girls grow up to be
women who know almost nothing about the biology of their own bodies or of the world around them. They do not know why their children so often fall sick and die, and not knowing the reason, they can do nothing to stop the result.

Benefits from risks

Traditions which are widely practised and which have continued for centuries are seldom uniquely disadvantageous. In societies in which subsistence is the norm, however, the advantage must be first to the tribe and only then to the individual. It is conceivable, for example, that withholding colostrum conserves the mother’s strength in the stressful postpartum days. Since a strong mother is a more valuable member of society than a fragile neonate, the practice of delaying breast-feeding may have developed to favour her at the possible expense of her offspring. Traditional practices which prevent early conception following delivery also serve to protect the health of the mother (4). The principle of survival of the fittest may be subtly invoked in prohibiting a mother who has already buried other infants from feeding her newest born: the weak line is likely to die out. Neonatal scarification, unsterile uvulectomy, and exposure to dense smoke and enteric and respiratory pathogens may likewise serve

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as a sort of crude traditional immunization process, condemning the weak and fortifying the strong.

No mother asks that her child may die, and the grief of a mother in one society is no less terrible for being much more common than the grief of a mother elsewhere. The difference may be that ignorance – the lack of understanding that her child’s death was easily avoidable – protects the uneducated mother and her family by preventing grief from drifting into bitterness and despair.

Weighing gain against loss

Health care personnel are charged with improving the quality of life of the people they serve by helping them maintain and improve their health. Modern health professionals do this through medical and surgical intervention, vaccination, education and co-ordination with other development workers. While introducing “beneficial” practices, they actively seek to abolish “harmful” practices which have maintained a society for generations.

The concerned populations are skeptical of such change. If the children are sent to school, who will shepherd the goats? If the weak are saved, who will care for the handicapped, and how will the expense be met? If centuries-old traditional “immunization” practices disappear, what will prepare survivors for the hazards of life? Why and for whose benefit should trust be confided in nascent, fragile government structures? Exactly who is seeking whose decreased fertility? And educate girls for what?

It is difficult to condemn the reticence of traditional societies which resist the advances of narrowly focused development programmes, particularly those determined to impose control on a population whose cultural existence is already threatened. No initiative is so urgent that it need be implemented unmoulded by close, careful regard for the history, beliefs and traditions of the people being advised or forced to change. National programmes in culturally heterogeneous
countries must be flexible. The complex mix of rituals and traditional practices which fill a culture is like murky water in an urn. The water is brown and cloudy and laced with germs, but the people who drink it know that it is water and that for generations it has been life-sustaining and sufficient. The urn is full, and whatever old water is laddled out must be replaced by new. If it is not, one day the vessel will be found not only empty but dried, cracked and fallen to pieces, the people chaotically dispersed and dying of thirst.

References

What are the functions of the first referral hospital?

The two basic features of a first referral hospital should be its concern with helping patients to find health (rather than only with curing disease), and its integration as a functional part of the district health system.

Being concerned with health rather than with sickness does not mean abandoning the hospital’s traditional curative role. It should rather add new dimensions to curative activities by recognizing that health is generated by many factors, of which the cure of a specific disease is but one. The search for health involves individual families and communities and a multiplicity of health workers, not just the doctor and the members of the hospital staff.

The hospital will have to recognize that it is not the centre of the health system, and that in practice its influence on the total health of the community is limited by comparison with that of such things as water supply, nutrition, vaccination, and individual behaviour. The hospital’s part may be small, but this does not mean that it is not essential. It has its own role in the flow of people, information, and materials through the district health system. Neither the hospital nor the primary health care facilities nor the community can be separate elements of the health programme: they are all intimately bound together as partners within a system providing health care for the whole district.