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Relations of Reproduction: Men, Masculinities, and Pregnancy in Dakar, Senegal

by

Richard Powis

A dissertation presented to
The Graduate School
of Washington University in
partial fulfillment of the
requirements for the degree
of Doctor of Philosophy

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St. Louis, Missouri

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Glossary

The following are keywords or phrases in the dissertation. All French, Wolof, and Arabic terms are transcribed into the International Phonetic Alphabet. Where appropriate, some terms have more than one pronunciation (i.e. French and Wolof).

accouchement humanisé (a.ku.ʃmã.y.ma.ni.ze [French] or a.ku.smã.y.ma.ni.ze [Wolof]): humanized birth (French); a globally institutionalized intentionality of childbirth practices whereby pregnant women are encouraged to develop birth plans with their provider, give birth in partnership with a relative or friend, give birth in comfortable positions, etc.

alhamdulillah (al.xam.du.li.la): praise be to God (Arabic)

affaire u jiggeen (a.fe.ry.dʒi.gɛn): women's business (Wolof)

bajen (ba.dʒɛn): the eldest sister of one's father (Wolof); a highly respected, very important relative and who often serves an advisory role to her brother's children

Bajenu Gox (ba.dʒɛ.nu.gɔx): neighborhood bajen (Wolof); a state program that trains highly respected women in rhetorics of reproductive health, pregnancy, childbirth, and child rearing so that they can advise their young neighbors; akin to doulas or childbirth educators

CFA (se.fa): the currency of Senegal (and much of Franophone West Africa)

CPN (se.pe.jɛn): consultation pre-natal (French); prenatal appointment

carnet de la santé (kar.ne.dla.sã.te): workbook or pamphlet of health (French); a book – authored by the state and shaped by global health organizations – given to pregnant women in public hospitals of health information and empty charts in which to keep personal medical records

chercher l'argent (ʃɛr.ʃe.lar.zã [French] or sɛr.se.lar.zã [Wolof]): to find the money (French)

comprehension (cõ.pre.ã.sjõ): understanding (French)

cosaan (tʃo.san): all that is and ever was (Wolof); generally mistranslated as “tradition”

DSME (dej.se.mø): Direction de la santé de la mere et de l'enfant (French); the division of MSAS that oversees all state hospitals, health posts, programs, and interventions that deal with maternal and child health (including pregnancy)

deellu (de.lu): a euphemism for a child who has died (Wolof), literally means “returned”

entourage (ã.tu.raz [French] or ã.tu.raz [Wolof]): those who surround (French); refers to those who actively support a central figure – in this context, a pregnant woman

goro (gɔ.ro): a woman's husband's mother

gris-gris (gri.gri): a magical/spiritual charm that one carries or wears which protects the owner from evil or misfortune, or attracts good luck

insh'Allah (in.ʃə.á.la): God willing (Arabic)

koleré (kɔ.lə.re): an historical relationship of mutual support between two families (Wolof)

MCH: maternal and child health

MSAS (ɛm.sas): Ministère de la santé et de l'action sociale (French); Ministry of Health and Social Action

marabout (ma.ra.bu): a Sufi Islamic spiritual leader

muñ (myñ): patience (Wolof)

ndoxantu (ndɔ.xan.tu): night walking (Wolof)

ngente (ŋɛn.te): the ceremony for naming a child seven days after the birth (Wolof)

njékke (ndʒə.ke): the eldest sister (or two eldest sisters) of a woman's husband (Wolof); "the female husband"

PMI (pi.jɛ.mø): Protection materno-infantile (French); Maternal Infant Protection, the French equivalent of MCH

tubab (tu.bap): foreigner (Wolof); depending on context, likely refers to white people (ex: *garabu tubab*: white people's medicine [biomedicine])

yërmandé (iər.man.de): a sense of pity for someone with a strong urge to act on their behalf (Wolof)

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Ku am kuddu du làkk
(Whoever has a spoon will not be burned.)
- Wolof Proverb

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I have, in the truest sense, written this dissertation in *and with* the memory of the late Paul Aspelin, Associate Professor Emeritus of Anthropology at Cleveland State University. Professor Aspelin taught my first course in anthropology in Spring 2010. He was an old school anthropologist, the kind I fight against so much today, but I know he would've appreciated it. He'd done his dissertation research among the Nambikwara in the Brazilian Amazon 30 years after Claude Levi-Strauss, but right when Levi-Strauss' publications were coming out, which made for some published sparring between the two of them. It all sounded so romantic and all of his students thought he was a legend. Professor Aspelin's door was literally always open and he rarely shooed anyone away when we wanted to talk. And then when I would ramble for what felt like an hour about how I wanted to start a disaster anthropology project at a Superfund site as an analog for postapocalyptic ethnography, he was patient and kind and nothing but generous. "Well. You should read Russ Bernard, I guess." Where Professor Aspelin really made his impression was in that introductory course. He had a way of capturing the imagination, particularly with his lecture about couvade. While I shelved "couvade" as an interest for a few years through my undergraduate years, returning to it is what inspired my dissertation research, and I have not looked back. Every word of this dissertation is shaped by that lecture and by my experience with him.

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Richard Powis

Washington University, May 2020

ABSTRACT OF THE DISSERTATION

Relations of Reproduction: Men, Masculinity, and Pregnancy in Dakar, Senegal

by

Richard Powis

Doctor of Philosophy in Sociocultural Anthropology

Washington University in St. Louis, 2020

Associate Professor Shanti Parikh, Chair

Around the world, global health initiatives aim to empower women by encouraging men to be more engaged husbands and fathers. In some forms, this means men attending prenatal exams and taking up a more equitable share of domestic responsibilities. In much of West Africa, spaces associated with women's work or "issues" are sharply gender-designated, meaning that even if men are open to engaging, they may not be welcome. This dissertation research is an ethnographic exploration of the experiences of expectant fathers in Dakar, Senegal, the ways in which they not only navigate these gendered spaces, and how they renegotiate their own masculinities in the context of locally-produced gender norms, changing forms of marriage, religious notions of parenting, and economic precarity. My research finds that there is tension between men's practices and gendered assumptions about men in global/national public health campaigns. I use the concept "absent presence" to examine the ways in which expectant fathers' practices and expectations are simultaneously a crucial part of prenatal care in Dakar while also elided from consideration in global, state, and scholarly interventions.



Chapter 1: Introduction

Ndank-ndank mooy japp golo ci ñaay
(Slow-going does one grab a monkey in the forest.)
– Wolof proverb

I was headed home in a musty old Peugeot cab. What was once soft interior had worn down to stiff, scratchy threads and it smelled of dry-rot and diesel. It was night. The streets were mostly empty, even in the bustling upper-class neighborhood that I was coming from. The streetlamps – where there were any – whizzed by as the driver picked up speed since there was no traffic nor pedestrians. It was so cold, especially this close to the beach, but I kept the window cracked open to keep me awake. I had just been well-fed and well-conversed by a dear friend who kept the beers coming. I love these quiet cab rides in the night.

My lethargy was interrupted by a call. It was Diouf. I answered.

“Hey, what’s up?” I asked.

“Fatou is in labor. We’re at *Hôpital Central*. There were tests and now I have to go buy medicines at the pharmacy but I’m out of money. Where are you?”

“In a cab, leaving dinner. I’m on my way! Give me ten minutes,” I said. We hung up. I was suddenly wide awake. I told the cab driver there would be a change of plans: I had to get to the hospital. When I arrived, the neighborhood was practically blacked-out, save for the one streetlamp over the entrance to the hospital compound. Diouf was standing under it.

As I approached the cashier at the front gate to pay Fatou’s hospital bill, I asked Diouf, “How is she? Can we see her?” Notably, *Hôpital Central* has the city’s only facilities (so far) to offer *accouchement humanisé* (humanized birth) services, so I had hoped that Diouf might get to be with her while she labored.

“The tests don’t look good. They sent her to *Grand Hôpital*,” he said. “We have to go pick up the medicines and take them to her.” I never figured out what the tests were for or what wasn’t “good” about them, largely because when Diouf asked the nurses, they wouldn’t explain any more than that.

Diouf led me to a scooter he had borrowed for the night. He handed me the prescription as he flicked his cigarette butt into the night. We mounted the bike and took off for the pharmacy, which was only a few minutes away.

I could tell he was anxious. The way he looked at me, the way he spoke to others, he was clearly panicked. We arrived at the pharmacy and Diouf waited outside while I went in to order the medicine and buy a pack of disposable diapers – there was barely enough room for two people to stand inside at the counter, so he didn’t need to go in. I came out to find Diouf holding two small plastic cups of *Nescafé*. “Here. We’re going to be here for a while.”

We walked across the street to *Grand Hôpital*, walked through the gate, across the long parking lot, and then the courtyard, and finally into the main entrance to find Fatou’s mother and sister. Diouf had a conversation with them, but I didn’t catch any of it. I was committing the space to memory – the open windows down the long corridor, covered by iron gates which looked out onto the courtyard, the leaves of trees poking through; the high ceilings, the tile floor and walls, the chipped paint; the dust that moved across the floor with every gust of wind; the nurses and midwives in their white scrubs who spoke to Diouf and Fatou’s female family members, but not him. I was thinking about the camera I was carrying which rarely left my side. The thought had crossed my mind that, if I really wanted to remember this moment, I should use it, but I ultimately refused what I felt would be an intrusion¹.

¹ “I chose to be an ethnographer instead of a journalist because I don’t have to always ‘take the shot,’” I remembered the visual anthropologist Jeffrey Schonberg telling me. “It’s okay to just put the camera down!”

“Let’s go,” Diouf interrupted my daydreaming. We walked across the courtyard to another part of the hospital – the hematology lab – to deliver the test results he’d gotten from *Hôpital Central*. I asked again what the test was for and what it said. (I didn’t understand the printed abbreviations and numbers, nor the handwriting.) “I don’t know. The midwives don’t tell me anything,” a phrase I would hear from expectant fathers many times over the next twelve months. “I just do what they tell me to do.”

We returned to the courtyard to sit, drink more *Nescafé*, and smoke cigarettes. Diouf, a linebacker of a man, kept shifting on the park bench – slouching with his head back staring into the night sky one moment, then hunched over with his elbows on his knees and head in his hands. We didn’t talk much – it was apparent that he was stressed out. What I didn’t know at the time was that he’d already had a very long day, and what I would learn even later is that his day was pretty typical for expectant fathers.

Diouf woke up early that morning, after the morning prayer, to make breakfast and get ready for work, like he always does. He’s a painter-plasterer (*enduseur*) by trade, but these days, he works mostly as a building contractor. He spends his days rounding up skilled tradesmen to work on various construction and renovation jobs (many of which he works on) and negotiating contracts with clients, many of whom are expatriates looking to move back to Senegal. This day, he’d been painting for about 10 hours before heading home. He gathered his belongings from the construction site, threw them into his backpack, and walked to the bus stop where the bus was waiting. Just as he was taking his seat, he turned his phone on and found 36 missed calls from his mother-in-law. “It’s Fatou! She’s given birth!” he recalled thinking in that moment. He called her back to find his wife was in labor and they were at a hospital near where he’d just left. He got

off at the next stop caught a bus going back toward the construction site. Fatou's mom called again – the hospital was sending them somewhere else, so he'd have to reroute again.

Frustrated, Diouf got off the bus and hailed a cab to meet them at the next hospital. When he arrived, he learned they were being told to go to yet another hospital. And at that hospital, they'd be urged to go to *Hôpital Central*, where I met him. All in all, Fatou had been bounced around between six hospitals while in labor². I was shocked, but over the following 12 months of research with over 40 expectant couples, I would only ever know one couple who went to just one hospital while in labor (although they were turned away and asked to come back days later – more on that in Chapter 8), while everyone else would be bounced between an average of four hospitals during labor.

Every hospital visit is an expense – consultation tickets, medications, tests, taxi fares, food, and drink. No wonder he was out of money by the time I met up with him. Here he was, shifting on the bench, chain-smoking, sleep-deprived, worrying, not knowing what was going on because “no one tells me anything.”

We went in again, walked down the long corridor to the delivery room which he was forbidden from entering. He wanted to know if he could see Fatou or talk to her somehow. “Does she have her phone?” the midwife asked. Diouf nodded suspiciously. “Just call her,” she said. He turned around, pulled out his phone, and started dialing. There he was, leaning against the wall outside the delivery room talking to his laboring wife – who was ten feet away from him – on the phone. “*Massa, massa*,” I remember him saying, a term used to soothe those in pain³. I didn't understand much else, but he spoke calmly for a moment, hung up, and walked back out to the bench where I followed.

² The one Fatou and her mother were at when Diouf first called was the second.

³ The term is typically used to mean “Sorry [for your pain],” “Take courage,” or “It'll be okay.”

About 20 minutes later, Fatou's sister came out and broke the silence. It was a girl. Fatou and the baby were doing well. It would be some time before they moved into the recovery room, so we just needed to sit tight. Diouf arched his back over the bench and hung his head back, letting out a sigh of relief. Then he sat up and looked at me. "They were just teasing me because now I have *two* girls. That's going to be a lot of work." I laughed, and he continued. "But one day, I'll have son and I can teach him to be a great *gardien* [goalkeeper]." I prodded, "You know, your girls can be great *gardiens*. Have you ever seen the US Women's Soccer Team?" He laughed. "Yeah, yeah, they're amazing, but we just don't do that here."

Before heading in, we ran out to a restaurant to get a small pizza and bring it back to Fatou. We found her there in a room of beds, covered, exhausted, half-asleep, in a daze, and small bundle of blanket next to her that contained the newborn. She pulled the blanket down to reveal a tiny face. The baby was significantly lighter-skinned than her parents. "Eh, is she a *tubab* (white person) or what?!" Diouf teased. He crouched down to get a good look at her and asked Fatou how she was doing while she sat up to take a slice of pizza. She wanted to sleep, but she was too tired. One of Diouf's friends came by to offer congratulations, and then we all left together.

Seven days after the birth, as is custom, is the naming ceremony called the *ngente*. The next week would be a trying time for Diouf. While the women of Fatou's entourage would organize the event (collect the money, buy and prepare the food, buy the gifts, have new clothes tailored, rent the pavilion and chairs, invite a band and griots, and so much more), Diouf needed to notify his family and friends that he had another child (because pregnancy is generally kept secret or not discussed) and get his own family's clothes tailored (as is his responsibility as head-of-household). But, even more importantly than any other job to be done in the organization of the *ngente*, Diouf needed to buy a ram (which can run USD\$500 to 1,500) worthy of sacrifice to ask

God to bless the newborn and her life. Without a ram, there is no *ngente*. With what little he had saved, getting the ram was not just a matter of finding the right one, but rallying family and friends to contribute funds as well – particularly expatriated relatives who regularly send remittances and more proximal foreign researchers (i.e. me) who could spare the cash. And of course, all of this had to be done without missing a beat in Diouf’s regular life – he still had to pull 10-12 hour shifts while he planned.

The story of the *ngente* for the baby who comes to be called Ida continues in Chapter 5, but I wanted to open with this story because it touches on many of the themes and arguments that arise throughout my dissertation.

Relations of Reproduction

My dissertation is about men, like Diouf, and their experiences of and perspectives on pregnancy and prenatal care. Until recently, few anthropologists have paid close attention to expectant fathers, their lived experiences, or the influences they might have on a pregnancy. All too often, men have either been ignored, they appear briefly in the backgrounds of ethnographies, or they appear as antagonists, obstacles, and gatekeepers to women’s health. My approach was not to invert that formula, rather to bring men into the research and emphasize their roles and perspectives.

One of the threads that ties the following chapters together is the theoretical concept of “absent presence,” a term coined by John Law in the early 2000s and recently more developed by Amade M’charek and colleagues (2014a, 2014b). In M’charek’s formulation, “absent presence” describes the way that racism in Europe is ostensibly absent from political conversation (i.e. that many Europeans find racism to be an American problem) and yet it is

concretely present in the lives of the people it afflicts. What I find so useful here is that the presence is made palpable by the absence – the refusal to recognize the problem makes the problem that much worse. My work takes a similar tack at multiple levels of analysis.

First, men in my study are absent from Euro-American conceptions of prenatal care – they don't have the same intimate relationships with a pregnancy in the way that Euro-American men might be expected too, precisely because they're working "to find the money" for the costs associated with the pregnancy. The same goes for varying amounts of emotional investment that men might make. In Chapter 4, I tell the story of Cheikh and Fama who had suffered through a number of miscarriages. While I was there and Fama was pregnant, Cheikh regularly retained emotional distance, not wanting to get his hopes up, as a way of providing care to Fama, but importantly, himself as well. And relatedly, as we see across all of the birth stories here, while women are in labor and delivering, men are absent, whether they are waiting in a hospital courtyard or running out to pick up medications or more money. In all of these cases, absence is a form of presence, rather than negligence.

Second, because pregnancy is considered "women's business" in Dakar, men don't get involved in more intimate ways, but they are given a way to exercise more involvement through the *carnet* and *Bajenu Gox*. The *carnet* is a pregnancy manual that pregnant women are given, which describes what to do and what to expect during a pregnancy, while *Bajenu Gox* is a community health program meant to verbally disseminate much of the same information as the *carnet*. As I describe in Chapter 6, by reading the *carnet*, men get a list of what pregnant women should do and expect, and in turn can make sure (or *surveiller*) that they are following the prescriptions and proscriptions, without getting too involved in "women's business." This is a type of absent presence.

Finally, men are absent from literature about anthropology and pregnancy, but also from global health scholarship, discourse, and interventions where men are absent as well, and that absence is mobilize but their absence can be mobilized as rhetoric of *absenteeism* or negligence, sometimes implicitly, sometimes accidentally. I will discuss this problem in greater detail in Chapter 7. As we will see, forms of men's involvement are absent from what USAID considers to be adequate prenatal care on the part of expectant fathers, which gives USAID an implied reason to act and intervene.

The way I take up "absent presence" as an analytical tool helps me to reform the idea of "absence" to argue that while men may not be apparent at all time in prenatal care, they are certainly not negligent.

The way I can do this is by drawing on Jennifer Johnson-Hanks' "vital conjunctures" in order to refigure pregnancy as a social phenomenon. Until now, much scholarship – both in medical anthropology and in global health – has implicitly or explicitly found pregnancy in the female body (to say little of queer or trans pregnancy). Johnson-Hanks (2002) argues that while anthropologists have tended to envision the progression of life to pass through bounded developmental stages – childhood, adolescence, adulthood, parenthood, elderly – that these stages are in fact characterized by exogenous markers of status imposed by "coordinated interventions" of the state, family, and other institutions. Drawing on concepts of vital events (or vital statistics) from demography, as well as Bourdieu's "conjunctures of structures and action," Johnson-Hanks proposes a theory of "vital conjunctures" which highlights the messy discordances between what is socially expected of individuals in any particular "life stage" and how they do or do not conform to those expectations. Unlike events, which purport critical moments of change from one stage into another, Johnson-Hanks argues that conjunctures play out over an indeterminate amount of

time. “Vital conjunctures are experiential knots during which potential futures are under debate and up for grabs” (Johnson-Hanks 2002: 872). Pregnancy, too, structures and is structured by the people it touches, beyond the pregnant woman herself. The Senegalese state and local religious authorities work together to produce an idealized version of how pregnant women should *be* pregnant – good and bad nutrition, healthy and unhealthy physical activities, and preparations for hospital deliveries – while her family undertakes the care work that may or may not meet those needs or even extend beyond them. In Dakar, as in much of the world, pregnancy is surrounded by simultaneous feelings of hope and good fortune as well as apprehension and anxiety. Nothing is taken for granted because everything is in God’s hands (*les mains de Dieu*).

Vital conjunctures are cast over entire social groups, as opposed to life stages which are ascribed to individuals. While an individual may ostensibly occupy a particular life stage, it is their social (or medical or political) environment that ascribes a label to them and may even enforce it. In other words, individuals are *treated as* teenagers or spouses or parents or elders – these are relational terms; they benefit from the privileges of those labels; so too do they suffer the consequences. Pregnancy also invites a particular disposition from those who interact with it – from a partner’s “belly-talk” (Han 2009) to the stranger who yields a seat on a crowded city bus.

Norma Mendoza-Denton and Aomar Boum (2015) have further complicated the tendency to view life as a progression of stages by challenging the assumption of linearity. Contrary to the transition from one stage to another in a socially prescribed sequence, stages are often “delayed,” “hopscoched,” and “opted out (of)” – modes that they term “breached initiations.” Elsewhere, I have also built on breached initiations to describe a Dakarais mode of “rushing,” in which couples may forgo a locally-expected and long practiced companionate marriage in favor of marriages of self-interest as a way of achieving social adulthood more quickly (Powis 2016; see also Foley and

Drame 2013). This sometimes happens very early in a young adult's life, but rushing into marriage is also practiced by those who had previously delayed marriage in their 20s, 30s, or even 40s. Paths that diverge from what is socially expected can, then, produce new and different conditions of how those events are experienced, and in this way, breached initiations alter both the order of events and the order of a given event. Crossing the circuitous path-making of breached initiations with the precarious aspiration of vital conjunctures sets the stage for thinking about pregnancy as a period of time for which prefigured social and material conditions are rarely ideal and implicate whole groups of friends, family members, and even strangers as actors and enforcers therein.

Therefore, in this way, I do not intend to argue that pregnancy is not a biological or somatic phenomenon, nor do I mean to downplay how women and children have been centered in previous ethnographies, rather I approach pregnancy through a lens of vital conjunctures in order to reveal more of the picture and to plainly state that non-pregnant people (expectant fathers in particular) can and do experience pregnancy.

The Arguments

This dissertation weaves together the descriptive with the analytical. I feel that the vast lacuna of information about expectant fatherhood (and men's grieving) necessitates this. If ethnography is an argument, then the overarching intervention is this: In Dakar particularly, there is a local convention for prenatal care in which caretakers (i.e. family members) are vested with diffuse responsibilities that are dependent on their kin-relationship to the expectant mother. Further, as a part of that team of caretakers (called the *entourage*), men have a quantifiably relatively minor role, but that role is qualitatively significant – in fact, local midwives say it is the most significant.

This intervention is supported by three main arguments. First, the way that men provide care pushes the logic of John Law and Annemarie Mol's thoughts on materiality (1995). There, they write that material and social conditions are co-constructed. As a simple example, I point out that without a (material) pregnancy, a (social) entourage could not form, but also given that pregnancy is a social phenomenon, a (material) pregnancy in Dakar would likely not manifest without a (social) entourage either. But when we look at the caregiving roles of expectant fathers – that they are expected to provide money and emotional support – we can see that social and material conditions can convert from one to another and co-construct their outcomes. We see this in the case of Cheikh and Fama in Chapter 4.

Second, I argue using rhetorical analysis that both the *carnet* (French: handbook) and *Bajenu Gox* (community health workers; Wolof: neighborhood aunts) are state programs that inadvertently (though perhaps by “happy little accident” [Ross 2017]) enlist Senegalese expectant fathers as agents of surveillance. In this way, as described above, men are able to “watch” that their pregnant partners are following the guidelines handed down from the state and donors, and even intervening, without being considered involved in “women’s business.” This is a particularly powerful mechanism of the state given that getting women to birth in hospitals is of prime concern in global health.

Finally, I argue that global health and development practitioners and scholars have the power to produce gender in global contexts. I make this argument by challenging the findings of a report released by USAID in 2018. In that report, they define “men’s involvement” globally, using sweeping, Euro-centric, and context-independent generalizations of what men should and should not do to elevate positive health outcomes for women and children. By defining the term without context, they set a standard for what “men’s involvement” should look like and then

have the power to create and implement interventions to correct what they view as negligence to their standard. It's not that they move the goal posts, rather they invent them in the first place.

Overall, what I intend to express in equal parts description and analysis is that expectant fatherhood in Dakar is nuanced and complicated, and that this single ethnographic study warrants looking into other perspectives and experiences of expectant fatherhood globally.

The Ethnographic Chapters

Following this Introduction, Chapter 2 provides an overview of the literature about expectant fatherhood. While there is little work about the subject in the last 20 years, the anthropological interest in men and pregnancy is contiguous with the subject of *couvade* which was popularized by E.B. Tylor in the late 19th century and hotly debated through the 1970s. Chapter 3 brings readers into the ethnographic setting with an overview of Dakar in its colonial and postcolonial context. There, I also describe the research methods used in this project and the challenges I faced.

Chapter 4, the innermost circle, is about the couple. Specifically, it is about the materiality of men's care. In it, I look at how men provide financial and emotional support to their pregnant partners. I take Law and Mol's argument that materiality and sociality are tightly intertwined and co-constructed, but I suggest that their formulation falls short of capturing the kinds of important emotional support that men are expected to undertake.

Chapter 5 moves outward to describe the relationship between the couple and the family. In particular, I take the perspective of two young girls (sisters) as proxies for the couple, as they benefit most from the extended family. I look at how kinship, gendered labor, fatherhood, and Islam come together to produce a network of support for expectant couples. This network is

called “the entourage.” In part, Chapter 5 builds on Chapter 4, in that Chapter 4 is describing what is expected of men, while Chapter 5 describes a broader context into which masculine responsibilities are situated.

Chapter 6 moves outward again, looking at the relationship between the couple and the state. I use rhetorical analysis to look at how a pregnancy manual authored by a number of global health organizations and handed to all pregnant women in state clinics acts to “articulate” women into being “good pregnant subjects.” Another facet of this work is the program *Bajenu Gox* which trains older women across the country to provide reproductive health and pregnancy-related advice to their younger neighbors. In the case of the manual, where many women are illiterate (and certainly in French, the language of the manual), men must read for them. This way, men see that they are not present in the manual (so too, in the *Bajenu Gox* lessons), further affirming to them that pregnancy is not “women’s business.” I call this “anti-articulation.”

Chapter 7 moves outward to the relationship between the couple and global health. It begins with an analysis of USAID’s report “Does men’s involvement influence women and children’s health outcomes?” What interests me in report is not the findings, but the method – how they define and measure “men’s involvement” is remarkably different from local understandings of involvement in Dakar. As a result, USAID’s document suggests that men are not involved because DHS does not track the ways that men are involved in Dakar. Further, it directs attention away from the more acute threats to women’s health: hospital nepotism and medical negligence. The chapter goes on to look at other ways that USAID (and development discourse in general) defines gender problems – not moving the goalposts, but inventing them in the first place.

Chapter 8 takes us to the level of God (or mortality). It's about how men grieve pregnancy loss and neonatal death. Here, I tell three stories about loss – a miscarriage, a neonatal death, and a kidnapping – and how men in each case reason between God's will and human actions that led to those outcomes.

In the conclusion, I reaffirm my arguments, make a claim to the global importance of this work, outline the limitations of the research, and introduce my next project.



Chapter 2: From Couvade to “Men’s Involvement”: Sociocultural Perspectives of Expectant Fatherhood

Xamxam du doy.
(Knowledge is not enough.)
- Wolof Proverb

This dissertation research bridges a number of bodies of literature as they relate to Senegal, namely: gender (e.g. Hannaford and Foley 2015), men’s reproductive health (e.g. Davids et al. 2011), transnational studies (e.g. Buggenhagen 2012), urban anthropology (e.g. Melly 2011), youth culture (e.g. Ralph 2008), and medical anthropology (e.g. Foley 2010).

On Masculinities

“Only recently,” write Matthew Dudgeon and Marcia Inhorn (2003:37-8), “have men as men – that is, as gendered agents, with beliefs, behaviors, and characteristics associated with but not depend upon biological sex – become subjects of theory and empirical investigation within the social sciences, including anthropology.” In this dissertation, I define gender as the social organization of practices and expectations according to “bodies and what bodies do” (Connell 2005) and masculinity as a specific set of practices and expectations associated with the bodies of men. Judith Butler has argued that although gender is a set of practices and expectations, rather than a naturally given essence, individuals perceive it to be natural (1993, cited in Morris 1995). Pierre Bourdieu has argued that this belief, or misrecognition (1977), compels individuals to adhere to gender roles because its social construction has been de-historicized and eternalized by “interconnected institutions such as the family, the church, the state, [and] the educational system” (2001:viii).

In Dakar, where pregnancy is *affaire u jigeen*, or “women’s business,” men are typically not seen in maternity wards, nor do they talk openly about pregnancy, labor, or delivery. As I show in this dissertation, many men in Dakar are facing the question of whether to be more hands-on. For those that do engage, it could indicate one of three things. First, it could mean that they are transgressing locally-constructed expectations of masculinity or “troubling gender” in the way that Butler describes drag performance (1990). Second, it is possible that those expectations are changing, particularly as some scholars have pointed to the ways in which gender has been historically tied to notions of health, hygiene, modernity, citizenship, and the state (see Wentzell 2015b). Finally, it is likely a combination of the two: men are reconfiguring or constructing novel forms of masculinity as the socially-accepted repertoire of gender is strategically reshaped by institutions (see Davids et al. 2011). What may seem to be a virtue of masculinity (e.g. accompanying one’s pregnant partner to a prenatal exam) to some men, may not be so for their peers. In order to capture the complexly shifting norms of masculinity, I employ theoretical concepts of *hegemonic*, *composite*, and *emergent* masculinities which acknowledge the myriad influences on and concrete manifestations of masculinity.

Hegemonic masculinity refers to naturalized and socially ideal sets of gendered practices and expectations associated with men (Carrigan et al. 1985), which are temporally fluid and differ according to local, regional, and global notions of ideal gender roles (Connell and Messerschmidt 2005). Historically, Senegalese men have certain obligations in their roles as fathers, husbands, and heads-of-household: Fathers are expected to, above all, provide education to their children (see Perry 2004), inculcate them with certain values like honor and dignity, usually by means of discipline (Diop 1985), and be a spiritual model (Edwin 2004). Husbands in Senegal are expected to “clothe, house, and satisfy” their wives – duties so taken for granted that

they are listed in the Family Code (Hannaford and Foley 2015:208), meaning that neglecting these responsibilities is grounds for divorce. As the *borom keur* (head-of-household), men are expected to fulfill their obligations as husband and father, as well as ensure financial security and manage the household finances (Diop 1985). In return, children and wives are expected to be unconditionally respectful and obedient; fathers are sovereign and authoritative (Perry 2009). For many years, the ideal Senegalese man was one who adhered to these practices and expectations, but did so while working to advance Senegalese society as a salaried civil servant (Melly 2011). Indeed, Senegalese tropes of masculinity featured prominently in the legendary, Senegalese filmmaker Ousmane Sembene's films *Xala* (see Mushengyezi 2004), *Faat Kiné*, and *Moolaade* (see Lindo 2010). Today, that archetype of masculinity, from what Donna Perry calls an era of "male triumph," is beyond reach; since the mid-1980's, Senegalese men have suffered a "crisis of masculinity" (2005). Indeed, in the aftermath of structural adjustment and neoliberal reform, amidst a struggling economy, rising unemployment and property prices, and increased immigration and emigration, masculinity of the bygone era has been threatened and reshaped. Perry (2005) documented cases in rural Senegal where fathers, unable to provide for their families and unable to discipline their migrant sons, have sought aid from the state for the latter. For men who engage *directly* with the pregnancy of their partners, this could mean adhering to local notions of a global form of masculinity that, due to international development initiatives, includes being involved in maternal and child health. Over generations, if engagement becomes more expected of men in Dakar, it may come to characterize locally idealized forms of masculinity as well.

Composite masculinities are "contingent and fluid constellations of acts, attitudes, relationships, and physicalities that men weave into coherent masculine selfhoods through a

variety of social and bodily practices” (Wentzell 2015a:179). In other words, men may adhere to a range of practices and expectations that characterize a variety of masculinities. Davids et al. (2011) have written on the ways that young men in Dakar draw on both local and global expectations of masculinity and health when engaging in premarital sex. As another rather simple example, Wolof fathers are expected to provide an education to their children while Muslim fathers are expected to be spiritual role models; in Dakar, where men are often Wolof and Muslim, they may opt to provide their children with a Koranic education. However, as my preliminary field research has revealed, masculinities do not always complement each other so well: a number of young unmarried Muslim men (18-40 years old) were in one or more sexual relationships, despite their knowledge that premarital sex was forbidden by the Koran, citing that such masculine promiscuity was simply expected of Senegalese men.

Emergent masculinities are the ongoing and iterative performances of masculinities that occur over one’s lifetime (Inhorn and Wentzell 2011). Marcia Inhorn and Emily Wentzell write that “manly selfhood is not a thing or a constant; rather, it is an act that is ever in progress” (2011:803). In Senegal, where transnational migration is a national dream – and an ideal component of contemporary masculinity – marriages between husbands abroad and wives at home are fraught with economic (Buggenhagen 2012), emotional (Hannaford 2015), and reproductive tension (Sargent 2006) as men are continuously renegotiating their manhood in the face of unforeseen challenges. Unemployed young men in Dakar await (*toog*) the opportunity to fulfill norms of adult masculinity, like going abroad (Melly 2011) or starting a family, but as they “kill time” (*tuer le temps*), they are popularly regarded as lazy (Ralph 2008; see also Jeffrey 2010 for an account of shifting masculinities during periods of waiting in India). An example also comes from my preliminary research in which one man in his mid-30s was intensely

invested in the outcome of his partner's pregnancy with their first child. He and his wife had already suffered through three miscarriages; he admits not being particularly engaged with the first, but became more and more engaged with each pregnancy after that. At the time of the interview, he was working more hours and spending less time with friends in order to save money, he accompanied his wife to her prenatal examinations when possible, and he even reported being emotionally moved when seeing a sonogram of his daughter. The concept of emergent masculinities is illustrated by this man's growing engagement over a series of pregnancies with what other men considered to be "women's issues." Taken together, these theories illustrate the temporally, geographically, and ontologically fluid notions of masculinity.

As it relates to my dissertation research, these theories shed light on the ways that men understand, navigate, and perform their own masculinities (e.g. urban, Wolof, Islamic, global). However, I rarely use these terms in this dissertation. Rather, I begin from the intersection of the concepts which demonstrates that the performance of masculinity - and gender more broadly - is messy and complicated: it changes according to context from one moment to another, it changes throughout life, it is shaped by structural forces, and it shapes itself in the process.

On Reproductive Health and Senegal.

Senegal has long been studied by foreign scholars for its perceived "exceptionalism" in sub-Saharan Africa, notably democracy and public health. For instance, the prevalence of HIV/AIDS in Senegal is among the lowest in sub-Saharan Africa. Scholars have attributed this to rapid government response (i.e. establishing sexual education campaigns, registering and testing sex workers, and allowing NGOs to mount their own campaigns), the widespread support of imams for these measures, and local practices such as high rates of male circumcision and low

rates of alcohol consumption (Davids et al. 2011; Foley 2010). Contraceptive-use is largely associated with women, but recent research shows that, nationally, contraceptive-use is low because women lack access (Sidze et al. 2014). Despite this, researchers have shown that men's use is highly correlated with exposure to television programming about reproductive health or hearing imams speak favorably about it (Okigbo et al. 2015). Currently, there is a grassroots youth movement underway, known as *Fagaru Jotna* (Wolof: Be Prepared, Protect Yourself), that has gained support from United Nations Population Fund (UNFPA) to promote reproductive health issues to both young men and women. With its substantial social media presence, *Fagaru Jotna* is engaging Senegalese youth on topics not only related to condom and contraceptive use, but underage marriage as well, and effectively aims to turn these "women's issues" into everyone's issues.

It is also notable that Senegal has a relatively low rate of maternal mortality and it has one of the lowest rates of infant mortality in West Africa. The picture of maternal and child health (MCH) in Senegal is by no means favorable – for instance, 29% of women of reproductive age suffer from malnutrition, 60% are anemic during pregnancy, and 15% of infants are born with low birth weight (Aubel et al. 2004) – but it fares better than its neighbors. One reason may be that there is a long history, going back to the early 20th century, of government support for the integration of MCH into the biomedical landscape of Senegal, which at the time was undergoing a major overhaul in medical education of women (Ndao 2008), women's professionalization (see Patterson 2015), and rural health campaigns (Kusiak 2010a). While no ethnographic research has been conducted to investigate what makes the state of MCH in Senegal better than most (or worse than it should be; or if those statistics are even accurate), one may hypothesize that it could be related to the kinds of kinship and social support networks

which Duana Fullwiley illustrates as an explanation for the so-called “mild” form of sickle cell that is endemic to Senegal (2010, 2011), or the kinds of larger community support networks that emerge in the form of grassroots campaigns like that discussed above. There is some evidence for such a hypothesis as researchers have shown the importance of Senegalese grandmothers and other senior women in the improvement of maternal and child nutritional health (Aubel et al. 2004). As it relates to this dissertation proposal, Aubel et al. found that husbands and other family members defer to senior women for advice about the health of their wives and children both during and after pregnancy and that, in turn, senior women delegate certain responsibilities to the husbands and other family members.

Aubel and colleagues’ research, which was conducted in rural Serer villages, is distinct from the urban context, in that it assumes that the mother and father are married, which is not always the case in Dakar. This is significant because, as they point out, the senior women tend to be (but are not always) paternal grandmothers (of the child) – it is unknown whether this makes a difference if the couple is not married. There has been some recent scholarship on the ongoing changes in marriage in Dakar. While my preliminary research shows that men’s desire for *de jure* polygamy is on the decline in the Medina neighborhood, marriage of some sort is still compulsory as a means for achieving social adulthood (Adjamagbo and Koné 2013). Dinah Hannaford and Ellen E. Foley suggest that reasons for marriage are changing as well (2015). Where some scholars have documented increased rates of companionate marriage, Hannaford and Foley, noting that companionate marriage has long been the tradition in Senegal, argue that women are beginning to pursue marriages of “self-interest” and financial security, rather than privileging kinship, caste, emotion, or social reproduction (2015:207). Additionally, in Dakar, the age at which women first marry is increasing, the divorce rate is increasing, and there is a

documented rise in transactional sex (Foley and Drame 2013). Both Hannaford and Foley, as well as Foley and Drame, situate these changes as women's strategies for navigating economic precarity. As of yet, there is no scholarship that considers these changes in either marriage trends or engagement with MCH from men's perspectives, and it is not yet known how these changes shape men's experiences or engagements.

On Couvade

There are probably as many articles critiquing the "problem" of couvade as there are articles about couvade itself. The problem of couvade – that is, the inconsistent and often contradictory ways in which couvade has been discussed and interpreted for the last 150 years – is bound up in problems of Western knowledge production. There has been little agreement about what defines ritual couvade and Couvade Syndrome, except that they are abnormal phenomena. As men's experience of pregnancy and child birth have been decontextualized and isolated to the male body, it has been a source of much fascination and exoticization.

Following Rivière's observation that the enigmatic legacy of couvade serves as a genealogy of anthropological thought (1974:424), I expand this view by reuniting the types of couvade into a single conceptual landscape in which specifically local interpretations might be situated. I argue that they are but one phenomenon under the gaze of two very different – though both entirely Western – ways of knowing. First, however, I will review a typical case of couvade as it is discussed in anthropology and then I will review a typical study of the Couvade Syndrome as described in biomedical literature. After discussing this new reconfiguration of classic couvade characteristics, I will discuss some examples of emergent research that fall under the purview of

“new couvade” and its possible applications which should prove to renew the concept as a site of fruitful scholarship.

Background

Where Dudgeon and Inhorn argue that “only recently have men as men ... become subjects of theory and empirical investigation with the social sciences, including in anthropology” (2003:37-38), they are correct to the extent that a refocusing of the anthropological lens is nascent. But an interest in men’s experiences of pregnancy and childbirth is by no means new. It is, in fact, one of the earliest objects of research in the history of North Atlantic anthropology. One hundred and fifty years ago, E.B. Tylor, arguably the father of North Atlantic anthropology, popularized the concept of couvade in his 1865 publication of comparative work, “Researches into the Early History of Mankind and the Development of Civilization.” There, it is discussed in the tenth chapter, “Some Remarkable Customs,” like an afterthought.

Most literature rightly attributes the coining of “couvade” to Tylor, but few scholars discuss from whom he borrowed it, and only one scholar (as far as I know) has picked up on his mistranslation (see Doja 2005). It is true that the word “couvade” is related to the French *couver* (to brood or hatch) and *couveuse* (a brooding hen), but Tylor took it from a description of Basque men who *fait la couvade*, which he took to mean that they perform the proscriptions associated with our current understanding of couvade. As it turns out, *fait la couvade* is a derogatory phrase meant to ridicule the men who, by “taking to childbed,” were not performing the hegemonic masculinity of France, the symbol of which is opposed by the brooding hen: the Gallic rooster (Doja 2005:920). Anthropologists have used this signifier for 150 years, and the concept has become no clearer since Tylor first misunderstood it.

Couvade has taken a number of forms in scholarly literature. Less than 100 years after its first use, Alfred Kroeber first called attention to the problem of its plasticity, writing that he believed couvade to be “a variable or series of intergrading phenomenon” (Riviere 1974:424-425). Writing a note for *American Anthropologist*, Harriet J. K. Kupferer (1965) dissented, opining that the word should not be used as indiscriminately as she argues it had been. After summarizing a number of forms of couvade from ethnographic literature, she demarcates two major types: real and ritual. She writes,

One is clearly an instance of psychosomatic or psychogenic illness. There is little question of simulation or imitation about it. On the other hand, the ritual couvade is most assuredly simulative or imitative. Nowhere is the suggestion made that the husband is actually unwell (Kupferer 1965:101).

Responding to Kupferer in the same journal, Lucile Newman (1966) prefers to distinguish between the types of couvade as two separate spectra of either “social” or “psychosomatic” behavior, thus delineating between voluntary and involuntary couvades (154). She suggests that a clearer description of couvade will facilitate a better understanding of its purpose, function, and cause in the future (Kupferer 1966:154). Later, Peter Rivière also distinguished between two types of couvade: ritual couvade and Couvade Syndrome (Rivière 1974:425) – a typology that has survived ever since, not only in name but in scientific understanding, and it is the distinction that I use here, if only to stitch them back together. For most anthropologists, it is a set of behavioral, nutritional, and sexual restrictions to which men adhere, sometimes during the pregnancy of their partners but often after childbirth for a set amount of time. Rarely is this form

identified in industrialized environs; couvade, as far as anthropologists are concerned, is the domain of Indigenous peoples and their “exotic ways.” Couvade, as it manifests among white men in the Global North, is under the gaze of biomedical scrutiny; a suite of psychological and physiological “symptoms” renders this version a “syndrome.” Thus, in academic literature, couvade is found among Indigenous peoples while Couvade Syndrome is a problem of “modern” men.

Ritual Couvade

Rivière’s (1974) description of Niels Fock’s account of the Waiwai of Brazil will serve as a typical case of couvade as it is problematized in anthropology. Couvade as it is practiced among the Waiwai features restrictions put upon the father during pregnancy and after childbirth (Rivière 1974:428). Toward the end of the pregnancy, it is the expectant father’s duty to build a birthing hut in which he and his wife will reside when labor begins, for fear that the blood of birth could pollute the communal house (Rivière 1974:428). Following the delivery, mother and child continue to stay in the hut for about two weeks – the father comes and goes, though always adhering to couvade behaviors, and the child is named (Rivière 1974:428). After a cleansing ritual, the mother and child move back into the communal house (Rivière 1974:428).

For the postnatal restrictions, Rivière relays, individuals from the society may give completely different lists – ultimately, it depends on experience and on the health of the child (1974:429). Here, he distinguishes couvade from a *rite de passage*, since couvade can be suited to one’s needs, so long as the purpose is the same: to accumulate the soul of the child and make it spiritually strong enough to be self-sufficient (Rivière 1974:429). As the souls of the parents are apparently tied to the soul of the child, any prohibited behavior or food consumption could

contaminate or impede the growth of the child's spiritual matter (Rivière 1974:429). Until the child's soul has been fully delivered, after about three years, they are referred to as *okopuchi*, meaning "little corpse" (Rivière 1974:429).

In 1865, Tylor first interpreted *couvade* as a mechanism of sympathetic magic. In his summation, *couvade* is exclusive to the "savage" psychology – a "confusion of imaginary and real relations" between a man and his child whereby there appears a belief that one is physically bound to the other (293). He would later revise his interpretation to be more consistent with his theories of cultural evolution – *couvade* marked a stage of transition from a matriarchal society to a patriarchal society (Tylor 1889). Functionalists, namely Bronislaw Malinowski (1927) and, later, Mary Douglas (1968) viewed *couvade* as a mechanism for "establishing social paternity by symbolic assimilation for the father to the mother" (Doja 2005:922) or establishing paternity where paternity might be ambiguous (Douglas 1968), respectively. Ritual *couvade* has also been interpreted through the psychoanalytic lens in which it is identified as one of a suite of psycho-sexual phenomena that aim to reconcile anxieties about castration, penis envy, womb envy, cross-sex identity, and unconscious sexual hostility (Doja 2005:925).

It is worth noting that Rivière explains that the seclusion, naming, and reintegration ritual of the Waiwai actually have little to do with the *couvade*, which he writes can last up to three years after the birth of the child (1974:428). Why does he bracket this time off as unrelated to Waiwai *couvade*, particularly after describing it as including "both pre- and postnatal restrictions on the activities and diet of both the father and mother" (1974:428)? I would argue that those particular rites don't fit into Rivière's idea of ritual *couvade* because their focal point is the family unit itself, not the father alone.

With respect to the ritual couvade, a Western fascination with men's involvement in pregnancy has exoticized the roles that they play in preparation for the imminent or recent birth of their children while overlooking the similar proscriptive behaviors of their pregnant or newly delivered partners. Laura Rival (1998) found in her work with the Huaorani that women were not participating in restrictions without their partners and that there was no documented case of men participating in couvade without their partner (622-623). Albert Doja would later use this generalizable finding to state that couvade is therefore not a rite of fatherhood, but what he identifies as "a rite of co-parenthood" (2005:930). Thus, while anthropologists have historically been interested in the father (or father-to-be), they have created a large blind spot for themselves by neglecting two-thirds of the triad.

Couvade Syndrome

In a study by Maria Kazmierczak and colleagues (2013), 143 Polish expectant fathers who attended antenatal classes were asked to fill out surveys listing 16 symptoms associated with Couvade Syndrome. They include nausea, vomiting, abdominal pain, flatulence, changes in appetite, weight gain or loss, intestinal problems, toothaches, skin problems, leg cramps, fainting, weakness, colic, diarrhea, and constipation. They were also asked to complete an "Empathic Sensitiveness Scale," which 117 men did. What they found was that men who indicated being emotionally sensitive (according to the Empathic Sensitiveness Scale) were prone to symptoms of the Couvade Syndrome. The authors state that their work confirms that of Brennan et al. (2007a), who found that men experience couvade when they are distressed or uncertain of their futures as fathers.

In another article by Brennan et al. (2007b), the authors critically review the literature that surrounds Couvade Syndrome. They begin almost immediately by stating that there is no mention of it in the Diagnostic Statistical Manual of Mental Disorders – Version 4 (DSM-IV) or the International Classification of Diseases – Version 10 (ICD-10), but that the Dictionary of Medical Syndromes defines it as a “neurotic disorder which occurs in men whose partners are pregnant” (Brennan et al. 2007b:174). They add that the incidence of Couvade Syndrome is highly varied all over the world and that sociodemographic factors are completely contradictory (Brennan et al. 2007b:175-176). Again, there are myriad interpretations. Some psychoanalysts have written that Couvade Syndrome is a manifestation of parturition envy, while others have claimed expectant fathers view the fetus as a rival (Brennan et al. 2007b:182-183). Psychologists hypothesize that Couvade Syndrome is what results when men are secluded from pregnancy or that men experience Couvade Syndrome as an embodied response to their transition into fatherhood (Brennan et al. 2007b:183-185). Finally, as Kazmierczak et al have stated (above; 2013), some see Couvade Syndrome as a mechanism by which men insert themselves into the pregnancy, either because of anxiety or the feeling of marginalization, by organizing and attending antenatal care, adhering to dietary restrictions, and so forth (Brennan et al. 2007b:185-187). Personally, I believe that Couvade Syndrome is a result of sympathy *activities* whereby expectant fathers’ diets change in step with that of their pregnant partners.

The search for a definitive cause of or reason for Couvade Syndrome is not unlike the exemplum that Scheper-Hughes and Lock (1987) share in their interrogation of Cartesian dualism in which a patient explains to a room of first-year medical students all of the determinants of stress in her life. Impatiently, one student interrupts to ask, “But what is the real cause of the headaches” (1987:8)? With respect to the so-called Couvade Syndrome, the

biomedical fascination with men's involvement in pregnancy has pathologized the physiological and psychological changes that they make in response to the imminent or recent birth of their children while overlooking men's contextual behaviors (Reed 2005:32-35). Richard Reed (2005) notes that a biomedical view of pregnancy locates it not only in the female body, but one that inherently deviates from the "normal" female body (72). To the biomedical gaze, for a man to experience pregnancy in any way, especially psychosomatic, is even more deviant. Pregnancy, for the medical practitioner, cannot be a social experience because medicine is not a social science.

Recalibrating Couvade

The argument that I make here is simple and it is based on three corollaries to the critiques that I have established above. First, all analysis of couvade originates in the West. It is overwhelmingly White European and North American scholars that have defined ritual couvade and Couvade Syndrome. As producers of hegemonic knowledge, their research and analysis on such phenomena sets the stage for the ways that men's subjectivity is treated in clinics, in discourse, and by global health and development scholars. Second, if one examines the total geographic distribution of ritual couvade (i.e. the Global South) and Couvade Syndrome (i.e. the Global North), one could suppose that some form of couvade is nearly universal, if only by virtue of the fact that it is so nebulously defined. Finally, the practices of ritual couvade are widely variable (Reed 2005) and the definitions of Couvade Syndrome are largely contradictory (Brennan 2007b; the latter of which I suspect intersects with local biologies [see Lock 1993]). Following these three points, I argue that couvade should be reformulated as a catchall for a partner's or alloparent's locally situated, conscious or unconscious changes in practices,

expectations, and physiology in the pre-, para-, or postnatal period. It is important that there is no distinction between ritual forms and psychological forms, and that it is inclusive of other persons in the community of care; indeed, future scholarship of couvade demands an anthropologically holistic view of all of the influences on one's experience. This recalibration of couvade would fashion it as a valuable tool in the emerging scholarship on men's subjectivities during pregnancy and childbirth.

Perhaps the most complete and most recent problematization of couvade comes from Doja (2005) in which he asks us to "rethink" how couvade has been interpreted and theorized over the last 150 years. While I agree with the core of Doja's argument that our conceptualization of couvade can be expanded, it suffers from the same significantly narrow and essentialist view of human societies that couvade has long been subjected to: it assumes family to be biological and nuclear, it assumes gender to be fixed and binary, it assumes life events to be synchronic, critical, and individually experienced [rather than a vital conjuncture], it assumes the practice of couvade to be abnormal with respect to gendered socialization (rather than to other periods of life), it assumes individuals to be rational, and it all happens removed from colonial extraction and neoliberal capitalism. On this last feature of couvade studies, the analysis of couvade in societies which are either seemingly vacuum-sealed from globalizing forces (which they are not) or removed from urban locales is an implicit reproduction of long outdated theories of social evolution. Theoreticians of couvade have historically tried to interpret a deeper meaning - the development or strengthening of conjugal bonds, the creation of a new person (or new people, including the parents), and even castration anxiety, to name a few examples. Couvade, in any case, is over-theorized and therefore overly complicated and completely out of touch with a reflexive and textured ethnographic engagement.

Beyond Couvade

“Only recently have men as men – that is, as gendered agents, with beliefs, behaviors, and characteristics associated with but not dependent upon biological sex – become subjects of theory and empirical investigation with the social sciences, including in anthropology” (Dudgeon and Inhorn 2003:37-38).

As I’ve shown, despite Dudgeon and Inhorn’s assertion, an anthropological interest in men’s perspectives of the reproductive health spectrum is by no means new if we consider couvade as an antecedent to renewed 21st century interest in men and fathers in historical, political, and economic context.

In the post-World War II United States and Europe, as Grantly Dick-Read, Fernand Lamaze, and Robert A. Bradley encouraged fathers-to-be to become partners in childbirth, there emerged a small interest in the social sciences in men’s roles in reproductive health as they manifested in those countries, though it was largely restricted to the work of self-styled sexologists, like Alfred Kinsey, William H. Masters, and Virginia E. Johnson. In this way, men were regarded as inseminators one moment and fathers nine months later. Anthropologists seemed to have little interest until Barry Hewlett published a large body of work in the 1980s and 1990s on fatherhood among the Aka Pygmies of the Western Congo Basin (see Hewlett 1987, 1994). Indeed, there exists a lot of work on fatherhood today, but I would suggest that it relates more to the role of the father in the family than it does the lived experience of transition into fatherhood – a transition that surely takes longer than parturition.

Dudgeon and Inhorn aren't wrong though – there is an emergent literature that subjectivizes “men as men.” While much of it has described men as “involved in the dramas of decision making” (Ivry 2009:282) or as influences on women’s reproductive health (Dudgeon and Inhorn 2004), there is a small amount of scholarly work on men’s experiences at different points along what I will describe as the reproductive and sexual health spectrum.

Here, I want to conceptualize the dense field of reproductive and sexual health as a loose chronology. Doing so allows one to manage the resulting parts and their relationships to one another in order to identify subjects in which there are large amounts of anthropological inquiry relative to other lesser studied subjects. I will then color the spectrum with gender, which will reveal a rather polarized result: attention to men tends to appear near the beginning of the spectrum, while women are studied along the entire spectrum. Finally, I will share some examples of vanguard research that interrogates the relationship between men, masculinities, pregnancy, and childbirth.

What I argue is that a woman-centered body of work on reproductive health belies not only men’s experiences of women’s pregnancy and childbirth, but even the idea that men can experience women’s pregnancy and childbirth in their own ways. Following Richard K. Reed’s argument that the Western form of *couvade* (which can include psychological and physiological change) is pathologized because a biomedical understanding of pregnancy is located in the female body (Reed 2005:72), I argue that because the hegemonic form of anthropological knowledge is constructed through the same Western framework from which biomedicine is derived (see Ribeiro and Escobar 2006), men’s subjective experiences in pregnancy and childbirth have gone overlooked as a serious site of inquiry for at least 150 years. Furthermore, as it will become apparent, the little work that does exist (ethnographic or otherwise) is done in

the Global North, thus there remains a vast amount of work to be done elsewhere. My goal here is not in establishing equal footing for men's reproductive interests with women's; I have no interest in furthering the arguments typically associated with men's rights advocacy. My intention is simply to call attention to the gaps in the literature – gaps that imply that there is a universal hegemonic ideal of masculinity which denies scholarly interest to the interval of time between conception and birth.

For the purpose of this literature review, reproductive and sexual health can be schematized in a chronologically linear spectrum divided into four sections of focus or phases – non-expecting, expecting, childbirth, and postpartum. Each phase refers to a period of time in which individuals are either expecting or not expecting the birth of a child, the childbirth itself, or a period of time following the childbirth, respectively. Within each phase is a number of phenomena that may or may not be exclusive to that phase; they may overlap and they are not necessarily linear in relation to each other, nor are they necessarily bounded temporally in relation to one another. While the phenomena themselves may serve as objects of academic study, the greatest interest to anthropologists is the practices and expectations with respect to a particular phenomenon. Here I will talk about each phase in more detail.

The non-expecting phase refers to the period of time in which individuals are participating in or abstaining from sexual activity or in which individuals are managing their reproductive health, but are not expecting the imminent birth of a child. Scholarly research in this phase typically focuses on topics related to sexual behavior and risk (see Davids et al. 2011), sexuality (see Niang et al. 2003; Poteat et al. 2011), sex work (see Sangaramoorthy and Kroeger 2013), contraceptive use and family planning (see Wynn and Trussell 2006; Sargent 2011), sexually transmitted infection (STI) avoidance (see Middelthon 2001; Yu 2013), infertility and assisted

reproductive technologies (ARTs; see Inhorn 2003; Roberts 2012), and adoption (see Seligmann 2009; Berman 2014). For reasons I will explain below, it is the work on this phase that represents the largest selection of literature on men’s relationship to reproductive health. Regardless of gender, the “non-expected” nature of this period of time dictates a common theme among each of the topics as initially unknown and unknowable. Indeed, childbirth may not be expected, though neither is the transmission of an STI or the discovery that one is infertile. Either one undertakes practices in which one does not expect unwanted consequences (e.g. by minimizing risk with contraceptive use) or one acts with expectation, but nonetheless must traverse a liminal period of not knowing the outcome (e.g. attempting to conceive a child or purposeful seroconversion). Sexual activity can be a site of reproduction – human, microbial, or social – and thus risk and uncertainty are major foci of scholarship among these topics, especially because understanding the probability of the occurrence of an event is so crucial to the successful design and implementation of public health interventions – interventions that arguably attract the largest amounts of global health and development funding. I will return to the topic of risk when I discuss the gendered nature of the spectrum of reproductive and sexual health.

The second phase, “expecting,” describes the period of time in which individuals are expecting the imminent birth of a child and concomitant phenomena include practices that manage the health of a pregnant person and fetus, prepare for the birth of the child, act to terminate the pregnancy, and so forth. Specific topics include abortion (see Storeng and Ouattara 2014), prenatal screening (see Rapp 2000; Taylor 2008), childbirth education (see Sargent and Stark 1989; Ketler 2000), surrogacy (see Teman 2010; Deomampo 2013), and couvade (see Brennan et al. 2007). Of the phenomena in this phase, only the study of couvade is male-centered – indeed, because, tautologically, couvade itself has historically been interpreted as a male-

centered phenomenon. Because of the subjective nature of expectation, these topics of study are often presented in terms of rational decision-making – a person, family, or community has information (i.e. a child is imminent) and one makes the decision to act or not act based on that information. Note that decision-making is only a common theme of the phenomena associated with expectancy, it is not necessarily the object of research.

The phase of “childbirth” refers to parturition and examples of subjects of study are birth models (see Davis-Floyd et al 2009), plans, narratives, obstetric emergencies (see Wall 2012), and placental practices (see Young and Benyshek 2010). In global health and development literature, much of the scholarship is aimed at maternal morbidity, maternal mortality, and infant mortality, usually as it relates to obstructed labor, delays of emergency care, and lack of resources or trained personnel.

Finally, the postpartum phase occurs after the termination of a pregnancy (for whatever reason) and subjects of interest during this period of time may be things like fetal loss (see Layne 2003), paternity testing (see Fonseca 2011), nutrition practices (see Moland and Blystad 2009; Chary et al. 2013), postpartum taboos (see Desgrées-du-Loû and Brou 2005; McKenna et al. 2007), and clinical depression (see Stern and Kruckman 1983; Harkness 1987).

For the most part, any phenomenon along the spectrum of reproductive and sexual health may be addressed with respect to one or any combination of intersecting frameworks, including decision making (see Sargent 2006), gender issues (see Mamo 2007), knowledge and power (see Jordan 1997; Hildebrand 2012; Storeng and Béhague 2014), science and technology (see Davis-Floyd and Dumit 1998), medicalization (see Treichler 1990; Pigg 1997), human rights (see Hörbst and Wolf 2014), political economy (see Mishtal 2010), and so forth. There are myriad possibilities of combinations between frames and phenomena, though while many combinations

have been addressed in one way or another, there exists an almost entirely neglected perspective from which to undertake ethnographic research: that of men.

The spectrum as I have described it is polarized by gender. That is, when men's reproductive and sexual health is a subject of scholarly pursuit, it is typically associated with the first phase of the spectrum – contraceptive use, sexual behavior, and infertility seem to be most commonly studied. This is a direct result of what Dudgeon and Inhorn have identified as the “post-Cairo era” paradigm shift (2004:1379). In 1994 at the International Conference on Population and Development, 179 countries signed a Programme of Action that would reconfigure the ways in which governments managed and promoted the reproductive health of their populations. Among the agreements was a new emphasis on men's roles in women's reproductive health which Dudgeon and Inhorn argue was followed by an emphasis in the study of men's influences on women's reproductive health for the purpose of the development of appropriate and effective public health interventions (2004). Of course, the literature on men at this end of the spectrum is not limited to the documentation of their influence on women's health; much of the work done on non-expecting men is about men who have sex with men (MSM), men who seek sex workers, men who are sex workers, HIV/AIDS avoidance behavior and serosorting, purposeful seroconversion, antiretroviral access and use, and so forth. While there is a growing literature on men's infertility and assisted reproduction, at this end of the spectrum, most of the concern with men revolves around risk – how men risk their own health and the health of others – and yet, there is little if any ethnographic work on how men experience and cope with testicular cancer (see Brodsky 1999) or prostate cancer (see Oliffe et al. 2009; Schumm et al. 2010), how young men make decisions and strategize to make or abstain from their sexual debut (Erickson et al. 2013), or how boys learn about and manage their reproductive health during puberty and

adolescence. One could surmise that the topics most associated with men, those related to risk and uncertainty, are those that seem most lucrative to the benefactors of global health and development initiatives because those topics focus on men as *influencing* someone or something else, rather than on men's lived experiences.

Likewise, when women's reproductive and sexual health is the focus of research, it tends to be associated with the latter phases of the spectrum – prenatal screening and care, surrogacy, birth models, fetal loss, breastfeeding, and so on. As Dudgeon and Inhorn have shown, there is a small amount of work on the ways in which men influence women's reproductive health all along the spectrum, but there are many lacunae as well (2004). The examples they provide include how men influence contraception, how men influence the transmission of STIs, men's influence on abortion, and how men cause fetal harm. In this gendered view, men are influencers acting on feminine or fetal passivity by taking risks and causing harm. While their argument is much more nuanced, it is the overarching theme (and title) of their article that aims to establish a collection of works on men's influences rather than men's experiences, and thus they inadvertently outline a major scholarly gap by omission.

Here, I will explore two examples of research that fail to consider male subjectivities. First, as Thaddeus and Maine (1994) have elucidated (and Dudgeon and Inhorn mention without citation [2004]), there are three types of delay when it comes to responding to an obstetric emergency: delay of recognizing the emergency, delay of transportation to an appropriate facility, and delay of proper treatment. In addition to a lack of resources, women who suffer an obstructed labor must often negotiate with men in their lives – partners, fathers, brothers, neighbors, physicians – who, as portrayed in such studies, can be gatekeepers of the resources that could secure successful health and birth outcomes for women and their children (Thaddeus

and Maine 1994:1098-9; Prevention of Maternal Mortality Network 1992); men in positions of power can exacerbate the delays, either by denying the urgency of the event, denying transportation to the woman, or denying immediate treatment once she is in a facility. However, this model obscures the interpersonal politics that men themselves must navigate in order to obtain such resources, it presumes that all men in a community work in concert to be negligent, and it depends on an idea that men even have access to the resources they are “withholding” in the first place. This nuance could make for a fruitful site of anthropological inquiry and yet it goes unquestioned. Dudgeon and Inhorn describe this as an example of how men influence women’s reproductive health (2004:1387), but I think that a more useful exercise would be in determining why men respond in the ways that they do – what experiential knowledge has shaped their particular response, and how can it be renegotiated in the future?

Second, as Cleland and van Ginneken (1988) have written, a considerable amount of work from the 1970’s and 1980’s has established a strong link between maternal education and the improvement of child mortality statistics – indeed, a seven to nine percent increase in the likelihood of survivorship for each year of a mother’s education. In this way, education becomes a reproductive health issue, and this is undeniable, but in their 1988 article, Cleland and van Ginneken seek out the mechanisms through which maternal education causes better health outcomes for children without questioning the ways in which fathers’ education does or does not play a role. Indeed, as Gakidou et al. (2010) point out, global rates of education for men and women are on the rise. They argue that as the gender gap in education seems to be on a trajectory of either narrowing where men are more educated than women or widening where women are more educated than men, so too will child mortality decline (i.e. younger than five years old; Gakidou et al. 2010:971). It’s worth stressing that while the increasing rate of women’s

education outpaces that of men's, the rate of men's education is still increasing. How does one separate the influence women's education from the influence of men's education on child mortality? In what ways – through what mechanisms, to follow Cleland and van Ginneken – does paternal education play a role in the health outcomes of children under 5 years old?

The greatest voids in the literature are found in the ways in which men experience the phenomena of the latter phases of the reproductive health spectrum for themselves, how those experiences shape the ways in which they manage their reproductive health, and how those experiences contribute to the production and reproduction of masculinities - many such questions I aim to answer in the following chapters. For instance, what do men expect from childbirth and fatherhood and from where do they derive those expectations? How do men prepare themselves for childbirth and fatherhood, and how does knowledge imparted by prenatal screening, prenatal care, childbirth education, family, friends, and media influence their preparations? How do men adjust to their roles as first-time fathers? In what practices and expectations do they engage and for what reasons? How do men navigate gendered spaces and conversations? How do men grieve unfavorable outcomes? Relatively few anthropologists have confronted questions like these.

In her research on *couvade* in Colombian men, Carole Browner (1983) takes a subject that had, until then, been explored from the perspective of men and instead turns to the pregnant partners of those men to investigate how they found meaning in men's pregnancy symptoms. This methodological inversion – taking a topic that is misrecognized as “a man's problem” and asking women about it – is similar to the inversion that I undertake in Senegal on “women's business,” - that is, phenomena that are typically misrecognized as located in the female body, but are actually shared mutually across social groups. The following are examples of literature in

which such an approach has been implemented and they serve as models of how I would expand traditional ideas of “couvade.”

In “Birthing Fathers: The Transformation of Men in American Rites of Birth,” anthropologist Richard K. Reed (2005) explores the roles that American men play in the latter stages of the reproductive health spectrum, including couvade, experiences during labor and delivery as they have changed over the last century, childbirth education and men as partners, and how men experience fatherhood. Reed argues that American men perform ritual couvade just as their South American indigenous counterparts do: men’s diets change as the partner’s cravings change (eating is social, after all), they undertake the preparation of the forthcoming baby’s crib and room, and they may abstain from sex (2005:58-63). Reed reasons that like some anthropological interpretations of ritual couvade in other cultures, the American couvade need not make sense scientifically, it only need make sense to the expectant partner as a form of acting in his unborn or newborn child’s best interest (2005:63-64). He is not only interested in interrogating the ways in which fathers are affected by pregnancy and childbirth, but he also explicates the historical transformations of American fatherhood relative to the biomedicalization of birth. Reed argues that as American birthing practices ebb and flow, so too do the meanings and experiences of men as partners and fathers.

More recently, the last quarter of the edited volume “Reconceiving the Second Sex: Men, Masculinity, and Reproduction” (Inhorn et al. 2009) is a collection of four chapters that focus on men’s subjectivities in the later phases of the reproductive spectrum. In the first, Tsipy Irvy (2009) explores what it means to “share a pregnancy” by working with Israeli couples attending childbirth education courses. She finds that the fathers-to-be must reconcile the biomedical knowledge taught in the course with the embodied experience valued by their own local

masculinities (301). Since the men in her study view the pregnancy of their partners as primarily a physical hardship, some men question the relevance of the courses and of medicalization (297), and as a result they find it difficult to define their roles in pregnancy and the childbirth process (299).

In her chapter “Making Room for Daddy,” Sallie Han (2009) argues that “belly talk” – the action of communication or contact with a pregnant belly and, by extension, the fetus inside – not only constructs and reinforces kin relations, but it also serves as a mechanism for American men to make the expected child and the pregnancy “real” (308), thereby reifying their roles as expectant fathers. Following the historian John Gillis, she suggests that as the American economy shifted to necessitate two incomes for middle-class households, so too did the roles of parental division of labor (315), thus leading to what Han and other anthropologists have described as a new, more involved model of American fatherhood. Ultimately, belly talk facilitates fathers’ “head start” into bonding with their expected child (319). I argue that belly talk represents the makings of a very socio-spiritual bond that unites the partner and the child in a way that is similar to bonds forged in classically anthropological descriptions of ritual *couvade*.

In the third chapter of the series, Janneli F. Miller (2009) documents indigenous childbirth practices of the Rarámuri in Northern Mexico which are unique not because women typically give birth without assistance, but because they are often assisted by their husbands. While the husband does not actually deliver the baby (the wife does this herself), he does have duties that we might typically associate with those of a birth doula – bringing warm water, deflecting unwanted visitors, keeping the other children occupied – as well as particularly local customs like peeling and delivering a pine log for the laboring woman to hold on to and, later, burying the placenta (337-8). Miller points out that, despite the apparent sex-segregation of Rarámuri

society, the division of labor is flexible in that men and women often trade certain tasks, and it is a cultural expectation that men assist their wives in childbirth (343). It is by sharing in such intimate and equal partnerships with their wives that they affirm Rarámuri ideals of masculinity (343) and that they produce and reproduce the “egalitarian nature of Rarámuri society” in their own families (345). The behavior of Rarámuri men, I would argue, falls into the new holistic definition of couvade in that their practices require partnership with the expectant mothers in order to protect her and the child.

In the final chapter, Maruska la Cour Mosegaard (2009) reveals another dearth of literature in the lack of scholarship on homosexual men’s pursuit and experience of fatherhood.

Contextualized in an ongoing legal and political debate about homosexual parenthood in Denmark, the discourse was largely related to lesbians and their desires to have children, to the exclusion of gay men (349). Mosegaard’s research describes the ways in which homosexual men navigate Danish law and reinvent Danish conceptualizations of kinship to become fathers, thus distinguishing their needs and strategies not only from those of lesbians, but from those of heterosexual fathers as well.

Biological anthropologist Lee Gettler and colleagues (2011) have found that following the birth of a child, men’s testosterone rapidly declines. Further, the authors find that interacting with dependent children suppresses testosterone (2011:16,196). Lower testosterone is associated with higher paternal investment and nurturing behavior (2011:16,196). According to the broad definition of couvade, the work of Gettler et al, while unmentioned in the article itself, might serve as a starting point for interrogating the ways in which couvade is hormonally manifest, perhaps differently in local contexts. And couvade need not even be limited to *Homo sapiens*. Sánchez Rodríguez et al (2008) found that expectant male cotton-top tamarins (*Sanguinus*

oedipus), as well as adult male and female alloparent helpers, gain about 3.3% of their baseline weight in the third trimester of the expectant female's pregnancy, though it isn't quite understood why or how (827). A far-reaching redefinition of couvade would certainly open it up to a primatological perspective.

Finally, in a 2011 study, researchers aimed to describe the childbirth experiences of Swedish first-time fathers using a phenomenological lifeworld approach and re-enactment methodology. By focusing on the lived experiences of men, Premberg et al. found that men intended to support and strengthen their partners-in-labor and that their experience – highly dependent on the state of his partner and the presence of health care providers – moved back and forth between overwhelming euphoria and agony (2011:849). They conclude that the consideration of hospital birth as a mutually shared experience could be both beneficial for the father-to-be and the well-being of the new family (852).

It should be mentioned that while there has been recent focus of scholarship on men's subjectivities and reproductive health, much of the work has been disproportionately limited to the Global North. This means there is virtually no literature on men's perspectives of childbirth in the Global South and, with respect to my own area of study, there is no such research that has been done in West Africa. Furthermore, excepting Mosegaard's aforementioned book chapter, there is virtually no published work on single or gay men and their perspectives of expecting childbirth or childbirth itself. All studies of couvade – ritual or syndrome – have systematically focused on heteropatriarchal forms of kinship, overlooking those created by assistant reproductive technologies, surrogacy, and lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) unions. This is fertile ground for researching the ways in which queer folks experience the pregnancies of their partners or surrogates. What does couvade look like for

queer and trans folks? How might couvade manifest in the tetrad of two expectant parents (of any configurable sexuality), a surrogate, and the child? What forms of ritual do they practice, in what ways do they construct a socio-spiritual connection with their unborn child, and how do they respond physiologically and psychologically to these expectations? Two scholars have only just begun undertaking ethnographic work that falls into a wider view of couvade. Michelle Walks et al have looked into how pregnant transmen engage with and are perceived by healthcare professionals. And Willow Rosen's nascent ethnographic work "Trans and Queer Babymaking" confirms that that no two lived experiences of prenatal care are the same, and that they are only generalizable in that people deviate significantly from their normal practices and expectations in response to pregnancy and in anticipation of a new family member.

Conclusion

In this chapter, I have outlined, firstly, multiple intersecting heuristics with which to think about masculinities. I rarely use them throughout the dissertation because I find that categorizing men and masculinities is neither productive nor analytically helpful, but I introduce them here to demonstrate the often counterintuitive practices and expectations that appear in my ethnographic works.

I have also highlighted a lack of anthropological research on men's subjectivities and reproductive health and that this oversight has obscured a great deal of holistic understanding of reproductive health as a lived experience. I have presented the concept of a spectrum of reproductive and sexual health. The illustration of the spectrum, its divisions, and their respective phenomena are not intended to be steadfast taxonomies – there are fuzzy lines and grey areas abound – and they are by no means exhaustive. Instead, this heuristic device - like those of

masculinities - serves as a tool which can be used to approximate differing types of academic engagement into the vast depth and breadth of possibilities in the study of reproductive and sexual health. Breaking it into pieces and parts renders it manageable for my ultimate argument, but it is conceivable that there are other conclusions to be drawn from such an exercise and that one may even find other uses for this schematic representation. I have argued and shown that the spectrum is gendered, leaving an anthropological perspective of men's experiences during pregnancy, childbirth, and early fatherhood largely neglected.

As pregnancy is regarded through a Cartesian understanding of the body, Western scholars have separated men from it. Because a partner's or alloparent's experience is psychological, it has thus been irrelevant to the interest of Western sciences (Reed 2005:73). Couvade, as either a ritual or a syndrome, is an incomplete tool for the study of the subjective experience of pregnancy. They are two sides of the same coin, and they must be treated as such in order to elucidate a full ethnographic account of a partner's experience. Historically, the literature on ritual couvade has emphasized men's deviance without taking into account that both men and women are acting together in the interest of the child, not to mention to what prescriptions or proscriptions other family members or alloparents may adhere. Likewise, scholarship surrounding Couvade Syndrome has insisted on pathologizing that deviance by neglecting the socio-cultural underpinnings of the expectant partner's lived experience. Framed by one's cultural practices and expectations, an ethnographic perspective should reveal how partners imagine themselves to contribute as a parent and how those expectations influence one's experience. While couvade, as it envisioned here, is inclusive of all genders, this reunion of the two historically opposing forms of couvade will lend itself as a valuable tool for the emergent scholarship on men's experiences of pregnancy and childbirth. I have presented several examples

of the emerging research that has challenged a mostly unquestioned woman-centered body of literature by documenting men's narratives of pregnancy, childbirth, and fatherhood. Pregnancy and childbirth are inherently social experiences and it will require an anthropological undertaking to depathologize and normalize men's subjectivity.



Chapter 3: Research Design and the Context

of Dakar

Lu bant yàgg-yàgg ci ndox, du tax mu soppaliku mukk jasig.

(No matter how long the stick stays in the water, it won't become a crocodile.)

- Wolof Proverb

Dakar is precarious. Geographically, it is situated at the terminus of the Cap Vert peninsula at the westernmost tip of the African continent; geologically, the peninsula is a *presque ile* – almost an island; socioeconomically, the population increases while the number of available jobs declines and infrastructure falls into disrepair.

Because of rapid population growth, Dakar is listed as one of the Rockefeller Foundation's "100 Resilient Cities," a program that funds innovative solutions that address the challenges particular to urban environments. According to the Rockefeller Foundation website, Dakar's "Resilience Challenge" is that "Uncontrolled urban development demands better management and policies to thwart the negative effects of large-scale urban growth." The website goes on to list such negative effects as climate change, water shortages, and energy disruptions, but further information about the causes or outcomes of such effects is lacking. Of course, people on the ground know – structural adjustment, migration, flows of global capital, crippling neo-colonial extraction of by French Treasury. Rockefeller – like many development and global health organizations as we will see later – paints an "apolitical" picture of Dakar in order to meet a particular political goal.

The population boom could be a result of both increasing rural-to-urban migration (ANSD 2014) and a demographic transition (Dankoko 2012), i.e. fertility rates are falling, and life expectancy is increasing. Senegalese cities are home to 45% of the national population; Dakar, the capital and largest city in the nation, is home to 41% of the nation's internal migrants (ANSD

2014). In the city, unemployment hovers around 14% overall and 16.8% among Senegalese youth (i.e. between 15 and 24 years old; ANSD 2015); the mean age of the country is 18, and youth make up one-fifth of the national population (ANSD 2015). There is a housing crisis in Dakar due to poor urban planning. And as emigration continues to rise (ANSD 2014), as much as 10% of the national gross domestic product is made up of remittances from the Senegalese diaspora (Orozco et al. 2010). Much of the income goes to building homes for migrants who intend to return – in the meantime, unfinished construction sites dot the urban landscape as a testament to the future (see Buggenhagen 2001 and Melly 2010).

In this chapter, I introduce the space and place of Dakar in a historical perspective and work my way up to the construction sites and the migrant labor. I think that the colonial and geographic views of Dakar play as much a part in my work as do gender relations and kin expectations, which I introduce in Chapter 5. Then I'll give a brief outline of the landscape of health statistics as it relates to the research. Following this, I'll explain my research methodology as I proposed it to the National Science Foundation and how I did (or did not) execute my plan with considerable, local challenges.

Senegalese History: A Brief Review

In contrast to Georg Wilhelm Friedrich Hegel's characterization of Africa as "the Unhistorical" (2001:117) or former French president Nicholas Sarkozy's supposition that "the African man has failed to enter far enough into history" (quoted in Richard 2010:2), the history of the Senegambian region is a deeply complicated and rich story – reconstructed from oral tradition, Arabic texts, and archaeological investigation – of kingdoms and empires, alliances and rivalries, and periods of war and peace. While there is little to be said outside of macrolevel

perspectives on social and political organization (Gellar 2005:16), the Senegalese historian Boubacar Barry (1998, 1999, 2012) has written extensively of the shifts in power, trade, and political economies, the rise and fall of states, and the resistance to external threats (e.g. Berber invasion) or concessions to them (e.g. Tekrur's absorption into the Mali Empire), all from an Indigenous perspective. I focus here on the history of Senegal as a colony, territory, and nation-state.

The first Europeans to arrive in the Senegambian region were the Portuguese who, in mid-15th century, established a trading post in the mouth of the Senegal River on the island of Ndar (later called Saint-Louis), just south of the Senegal's current northern border with Mauritania. Previously, Arab and North African trade routes on the continent ran from north to south and into the interior, but as Barry argues, European presence attracted increased trade to the coast in a way that eventually destabilized interstate relations in a whole new way, destroying kingdoms, empires, and confederacies (1999:262). By the 17th century, the coast would be divided and occupied by Portuguese, Dutch, English, and French trading companies that exploited gold, ivory, leather, and slaves, though only the English and French would have a lasting presence. In 1659, the French founded Saint-Louis as a permanent trading post and military base. As the French worked their way through the interior and down the coast, occasionally engaging with other European powers in battle and negotiation for territory, most of the Senegambian coast had given way to French occupation – with the exception of the Gambia, which remained under British control until formal independence in 1965.

Slaves were not only a major export (as many as 500,000 just from the Senegambian region between 1681 and 1810 [Barry 1998:63]), but a political linchpin in the reconfiguration of the region's societies (Barry 1999:266). As *ceddo* (Wolof: animist) regimes (i.e. military states and

warlords) exploited local populations for the slave trade and effectively redrew state boundaries (Fig. 3.1), Islam, which had long existed in the region due to Trans-Saharan trade – though not to the extent that it does today – became a powerful movement against human trafficking and, by proxy, European influence by the 18th century (278). This resistance strengthened alliances between the slave-trading monarchies and Europeans (285), and after a series of Muslim revolutions, some of which were initially successful but ultimately short-lived, Islamic influence waned as did the slave trade, which was finally outlawed by European powers in the early and mid-19th century (299).

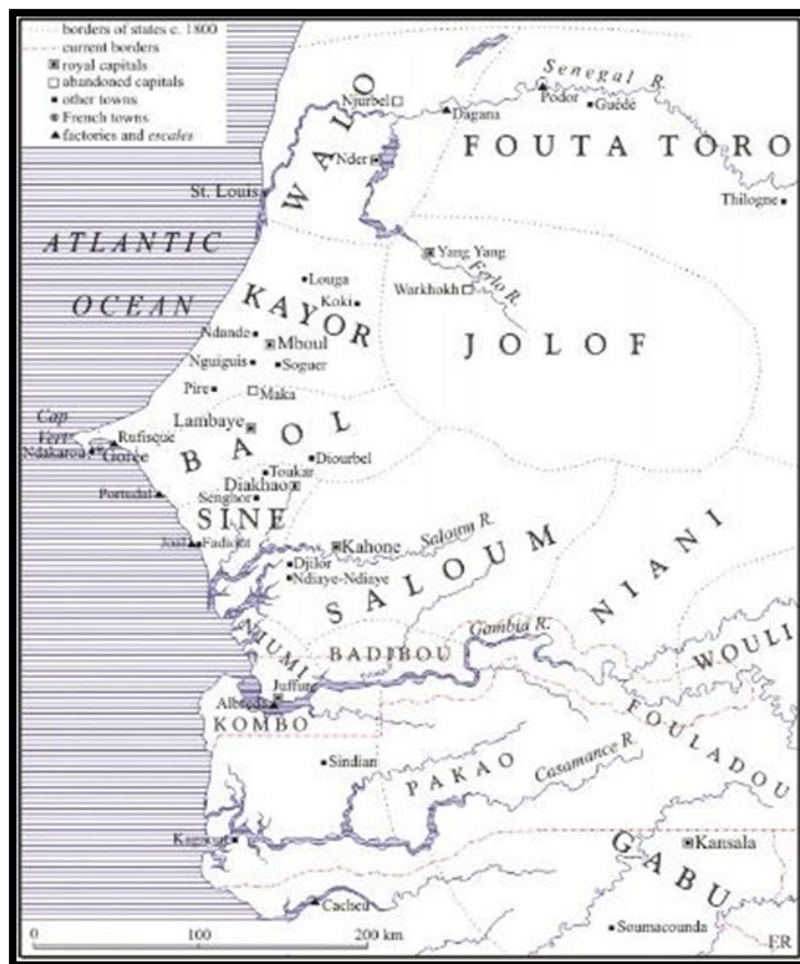


Figure 3.1. Political map of Senegambia, ca. 1800, courtesy of Eric Ross.

Once the French had established their dominance in the region, the *mission civilisatrice* (civilizing mission) was well underway. This colonial mission was rooted in Enlightenment philosophy in which all humans were equal, or at least had to the capacity to be, and it had in large part been a successful strategy in the construction of the French nation-state (see Weber 1976). Thus the French – positioning themselves as the telos of cultural and intellectual advancement, according to the mission – saw it as their duty to help their colonial subjects “become” French. To that end, the Four Communes were established – the cities of Saint-Louis (1872), Gorée Island (1872), Rufisque (1880), and Dakar (1887) – in which all rights of French citizenship, including suffrage and legislative representation, were extended to those born in those cities; they were referred to as *originaires* or *citoyens* (citizens). In 1890, the French would undertake a policy officially called *assimilation* that sought to actively reshape government administration in the *oultre-mer* (overseas territories) and immerse local populations in French culture and language (Betts 1961; Crowder 1962). These goals were pursued intentionally and strategically through French education (see Diouf 1998; Johnson 2004; Genova 2005; Wilder 2015) and biomedicalization (Betts 1971; Ngalamulume 2004, 2012; Ndao 2008; Foley 2010; Kusiak 2010a, 2010b; Patterson 2015). Residents of the Four Communes, in theory, were governed by the French *code civil*, while those outside of the communes – *indigènes* (natives) or *sujets* (subjects) – were held to their own *statut personnel*, or “private law,” a combination of local and Islamic laws as locals saw fit (see Mamdani 1996 for a discussion of colonial administration, the “bifurcated state,” and the construction of *citoyen* and *sujet*).

At about the same time in the latter half of the 19th century, drawing on its anti-colonial history in the region, the influence of Islam regained a significant foothold in response to increased French occupation, particularly after it was reasserted at the Berlin Conference of

1885. There, European powers laid claim to African geographies and from among them a federation of eight territories called *Afrique occidentale française* (French West Africa; hereafter AOF) emerged that lasted until formal independence in 1960. It was in this period that Muridiyaa – one of the largest Sufi brotherhoods in Senegal today – was founded by Cheikh Amadou Bamba (Babou 2007), contemporaneously with a revitalization of the other largest brotherhood, Tijaniyya, under the leaderships of El Hadji Malick Sy and Cheikh Ibrahima Niassé (Wright 2013). As political scientist Crawford Young writes, “Islam represented the most comprehensive ideological challenge to hegemony available for Africa at the moment of subjugation ... it offered a transcendental justification for resistance and a religious imperative for politico-military organization on a scale beyond ethnos and polity as these then existed” (quoted in Wright 2013:205). In the Four Communes, Islam served as a basis of resistance to assimilation policies and adherence to the French *code civil* (Diouf 1998). But while many Sufi leaders simply wanted to be left alone to worship on their own terms, Islam was also a powerful force in the movement for decolonization in the first half of the 20th century (Wright 2013).

During the construction of the Fifth Republic of France in 1958, President Charles de Gaulle gave the colonies of the AOF a choice between formal independence and a new constitution that would give them autonomous state governments. Of the eight, only Guinea chose formal independence, but in 1960, between growing anti-colonial movements and France’s (at that point, six year) war in Algeria, the “French Community,” as it was then euphemized, was dissolved. In Senegal, Leopold Senghor was elected president, which he remained for 20 years until stepping down and effectively passing the office to his Prime Minister, Abdou Diouf. After another 20 years, in 2000, longtime opposition candidate Abdoulaye Wade was elected

president, ending 40 years of the reigning *Parti Socialiste*, and, following massive protests (discussed below), his former Prime Minister, Macky Sall, was elected president in 2012.

On the surface, Senegal is the only West African country to have never suffered a military coup and has always enjoyed peaceful transitions of power. As a result, policy wonks, social scientists, and historians have had an interest in what is called “the Senegalese exception,” or why democracy works in Senegal but does not seem sustainable elsewhere in West Africa (or on most of the continent, for that matter) - a philosophy that does nothing but generalize all African nation-states, ethnic groups, and communities. Sheldon Gellar has suggested that democracy maps onto precolonial concepts of governance: rulers of the *ceddo* monarchies were “selected from an electoral college consisting of representatives of the different orders, religious communities, and ethnic minorities, and could be deposed if they abused their power or violated traditional norms” (2005:18). Boubacar Barry (personal communication) has spoken of the “strategy of the boa,” a Wolof concept that expresses the patience an electorate must have, waiting for the moment to strike at a politician or party they do not like (i.e. to vote them out of office). The overwhelming influence of Sufi brotherhoods on the Senegalese population has also been invoked as a powerful check-and-balance to Senegalese democracy (Villalón 1995, 1999; see also Mbow 2008). Finally, Michael Ralph (2015) has written on the way that Senegal’s “forensics of capital” – the process by which social standing (of an individual, community, nation) is judged – has been finely honed over centuries of European contact in such a way as to render its image as one of trustworthiness and creditworthiness, one that encourages positive diplomatic relations, particularly with the United States, despite the fact that Senegal actually does suffer through periods of violent protest and violent state-military response, censorship, alleged election rigging, and corruption.

The Medina

Of the Four Communes, Dakar has a rather brief history with respect to European presence. While the nearby island of Gorée had been occupied by the Dutch, British, and French (changing hands fifteen times between 1677 and 1814), and was by all accounts unoccupied by any Indigenous population (though that is doubtful), it wasn't until 1857 that “a small band of Frenchmen sailed the mile of water separating the old French establishment of Gorée Island from the mainland of West Africa” (Betts 1985:193; see Fig. 3.2) to the southern tip of the Cap Vert peninsula. According to the historian Raymond Betts (1985), the French were greeted by the Lebou inhabitants (and probably the single Catholic mission that had already been established there [Diouf 1998:681]), negotiated a treaty and stationed some men there. “There was no bloodshed and, surprisingly enough, there were no initial mistaken intentions on either side. Dakar was thus founded, quite uneventfully” (Betts 1985:193). At first, Dakar – *Ndakaaru*, in Wolof – was only occupied by a few colonial administrators, traders, and merchants, both European and African. Aside from serving as a refueling station, Dakar had little practical benefit to the region – Saint-Louis was already the capital of the AOF and the Senegalese territory, Gorée was already a military outpost, and nearby Rufisque was already the commercial hub (Betts 1985:195). But in 1902, following the Fashoda Crisis of 1898 involving a territorial dispute in East Africa with British military forces, the *metropole*'s hypervigilant response was to establish both a strong naval base and the administrative capital of the AOF in Dakar (Betts 1985:196).

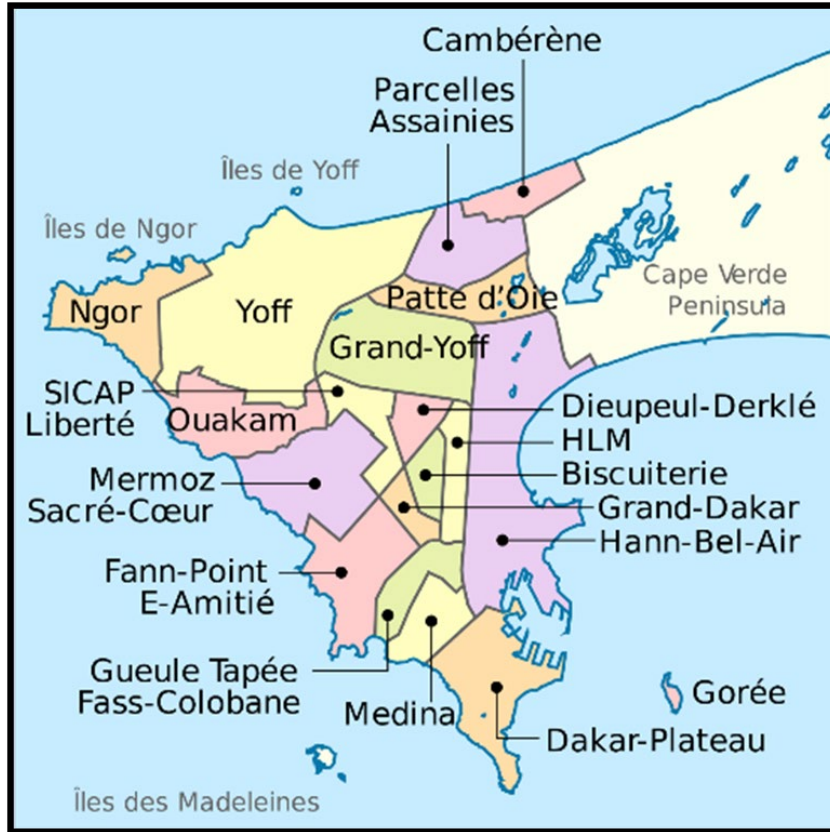


Figure 3.1. Political map of Dakar, 2013. Courtesy of Wikicommons.

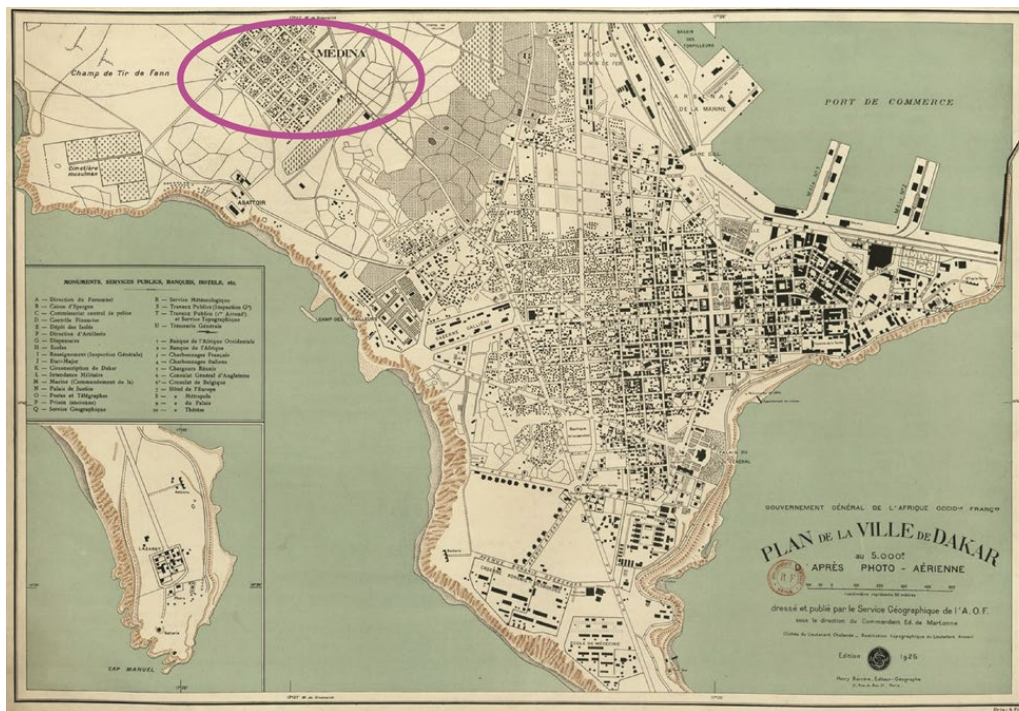


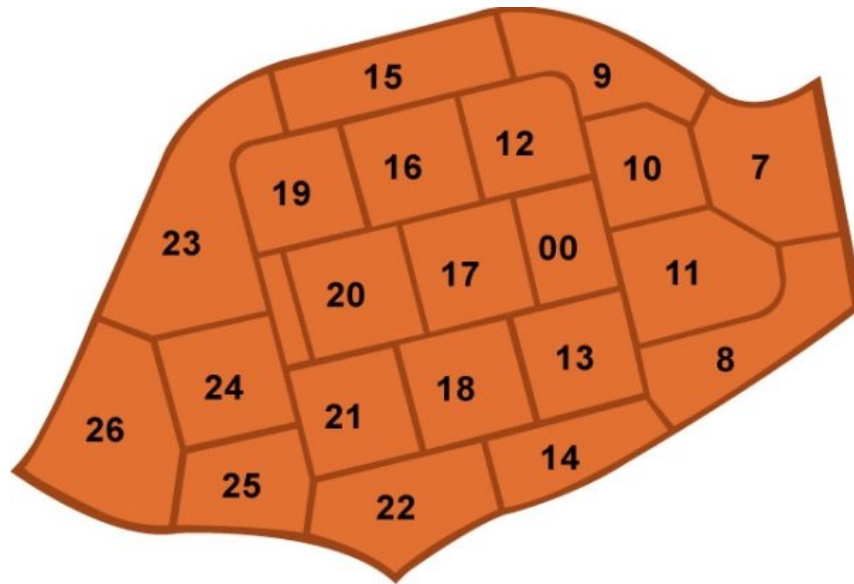
Figure 3.2. Aerial Map of Dakar, 1925.

Courtesy of Gallica, La Bibliothèque Nationale de France.

Until 1914, residents of Dakar (mostly French citizens, due to the policies of the Four Communes) lived mostly in the eastern half of the present-day Plateau (see Fig. 3.2) while the *indigènes* lived adjacently along the western edge. In 1914, following the declaration of an outbreak of the bubonic plague, the French quickly assembled a local health committee and decided, among other solutions, that Dakar-proper would be sanitized in two ways. First, the straw huts and shacks would be burned to the ground or otherwise dismantled. Residents were welcome to rebuild their homes *à l'euro péenne* (i.e. in brick and mortar). Second, for the African inhabitants who could not afford to rebuild, they were to move to a newly French-created village separated from Dakar by a quarantine zone to build homes with French-assistance (with considerable help from African and African-sympathetic politicians). This village was called The Medina (see Fig. 3.3). The decision was acted upon hastily, to the distress of the local Lebou population who believed that the French were retaliating against them after the election of France's first African National Assemblyman, Blaise Diagne. (Representatives from Senegal before Diagne had always been European.) Not wanting to move to The Medina, much less transition through a quarantine zone, the Lebou responded with protest and threatened armed insurrection. The French ultimately allowed them to skip quarantine and go straight to The Medina, but the French were so thinly spread between the Lebou relocation and the onset of World War I, that they were never able to fully develop or plan the village. Running water, proper sewage and waste removal, and paved roads wouldn't appear in The Medina until after WW1, and in the meantime, the village was located in low-lying and sandy land, prone to annual flooding and unstable building foundations (Betts 1971). According to Betts, The Medina remained “a blight” at the time that he wrote the history of its invention in 1971 (152).

Parcelles Assainies

It would be tempting and frankly easy to represent Medina and Parcelles as opposite ends of a historical progression, so it's important to outline how Medina and Parcelles' histories set them both up for remarkably different trajectories. At the time that Medina was being built and populated, the land mass of the Cap Vert was not under any immediate threat of urbanization. The history of Parcelles-Assainies ("sanitized plots"), or Parcelles for short, is directly linked to one of land shortage and overpopulation. The popular neighborhood has nearly twice the population of The Medina in about the same space, which is subdivided into 19 plots (or *unités*). Medina's popularity and location near the university make Parcelles' population relatively older, too. Aesthetically, Parcelles looks to be as old as Medina (architectural styles don't vary much between the two) but local residents have told me that the neighborhood didn't exist before the mid-1980s. "This was all desert! Nothing was here," Diouf told me. The rapid expansion and construction of the neighborhood over the last three decades is indicative of what the future may hold for newer nearby neighborhoods as the state expands residential districts east, further away from the peninsula, including Keur Massar and Diamniadio. The scarcity of land on the peninsula has driven the prices sky-high. Diouf's late grandfather bought a plot there in the 1980s for less than \$500 – today, without the building that stands on it, it would sell for 100 times that. This is where we built our home.



COMMUNE D'ARRONDISSEMENT DES PARCELLES ASSAINIES

Figure 3.3. The unites of Parcelles. Courtesy of Wikicommons.

Parcelles and Medina are socioeconomically similar – both are lower/working-class areas. Because Parcelles is a relatively new quarter, the infrastructure is not as well-established or even in place. Far more sandy paths, alleyways, and streets traverse Parcelles than in Medina where they are all paved. Buildings are shorter – two to three stories, usually – and construction sites, workers, and storefronts selling construction materials are more plentiful. While there are few published resources on this neighborhood, we can glean some related things about Parcelles from resources on the adjacent neighborhoods. Like the neighboring oceanside quarter of Yoff, which is also on the northern coast, residents often contrast themselves socioeconomically with the Dakarais of the southern peninsula and of the interior. It's common to hear that *Medinois* are uppity, loud, and rude urbanites while *villageois* are backwards and uneducated. Medina is a vibrant, colorful, and bustling popular quarter at virtually all hours of the day, while Parcelles tends to quiet down when it gets too dark to see without the aid of nonexistent streetlamps.

HEALTH STATISTICS

As of 2017, the maternal mortality rate (MMR) in Senegal was 315 per 100,000 live births⁴. While this is in no way acceptable – it is 35th highest in the world – it’s remarkable that among its adjacent neighbors, Senegal is the only country to have less than 500 deaths per 100,000 live births – and significantly so. (For comparison, the MMR in the United States is 19). Infant mortality in Senegal is 32 per 1,000 live births⁵. Again, this is unacceptable, but it is the lowest in the region. (Infant mortality in the United States is about 6.) While I can’t say why Senegal has relatively more favorable health statistics than its neighbors, we could speculate – as other scholars have with respect to other “exceptionalisms” such as “Senegalese democracy” or the low prevalence of HIV/AIDS in Senegal – that it is the result of some combination of close relationships with colonial superpowers and the imbrication of state and religious authority in Senegalese life. It’s also important to consider the validity of the numbers, particularly in light of Senegal’s data retention strike from 2010 to 2013 (Tichenor 2016).

In either case, the numbers set a starting point for global health and development organizations which have moved and continue to attempt to move the needle on these and other health statistics. The needle, of course, was motivated by the Millennium Development Goals (until 2015) and now Sustainable Development Goals. The interventions have tended to adhere to certain tenets of the global Safe Motherhood Initiative – a campaign started in 1987 with the goal of reducing maternal mortality by 50% by the year 2000. Over the years, state and NGO interventions that mobilize the SMI ethos have evolved, most recently targeting men as partners in the health of their partners and children. Those initiatives include education and outreach

⁴ <https://www.cia.gov/library/publications/the-world-factbook/fields/353.html>

⁵ <https://fred.stlouisfed.org/series/SPDYNIMRTINSEN>

about topics such as birth planning, contraception, the importance of hospital births, and recognizing obstetric emergencies.

RESEARCH DESIGN

In 2013, I was invited to stay with the brother of a former classmate, Diouf, and his grandmother in Medina - a neighborhood we were warned not to enter when I was studying French in Dakar the year before. Diouf is the oldest of six siblings. In 1992, his professor father was offered a tenure-track position in the United States. Diouf, 16 years old at the time, is not getting along with his father and he sees this as an opportunity to get out from under his authority. He fights and wins to stay in Dakar, arguing that he's too old to start learning English. What he didn't realize at the time was that no matter how far from home his father was, he still reigned supreme of Diouf's life. In 2005, Diouf moved to France to enroll in vocational training and allow himself to be tempted to pursue a childhood dream: play for a French football team – but that dream didn't work out, and he started a very successful business in construction. In 2010, he found himself – for whatever reason unbeknownst to him to this day – unable to renew his visa. He pleaded with a magistrate, “I've never done drugs, I've never had a sip of alcohol, I've never hurt anybody; I have a business, I pay my taxes, I've never been in trouble with the cops; I love France. Long live France!” The magistrate understood and believed him, but nothing could be done. Given the time to retrospect on his experience and what he's learned since coming back to Dakar, if you ask Diouf how he feels today, he'll say, “Fuck France and fuck Sarkozy.” When young men announce their dream to work abroad temporarily (a sort of Senegalese dream for many young men), he does what he can to paint France (and the US) as

dystopian for Black, Muslim immigrants, and then encourages them to stay and help develop Senegal “from the inside.”

By 2015, when I was a guest in his home a second time, his father had told me I should foster my relationship with the family as if I was his own son and Diouf’s brother, and that I could begin using their family name and drawing on family ties to government resources if I needed. Over the years, Diouf has taught me everything from speaking Wolof to *how* to speak Wolof *to whom*. He corrected my French. He taught me how to negotiate with cab drivers. He taught me how to walk and when to run. His experience working with *tubabs* in France positioned him to be a perfect interlocutor and cultural translator. “T’est senegalais maintenant!” (You’re Senegalese, now!) he’d say whenever I nailed my accent, the small talk, or a price negotiation in the market. But the most priceless lessons were learned from watching him *perform* work ethic, kinship, communitarianism, and masculinity. We’ve known each other for seven years, but it feels like he’s the brother I never had. In 2015, we were arrested together and interrogated by the *gendarmes* on suspicion of espionage. In 2016, I watched him verbally divorce his first wife over Skype. In 2017, he told me the news that his daughter’s mother was pregnant with their second child (which is not an insignificant admission, as this dissertation will attest). In 2018, we built a house together from nothing for him, his wife, and their kids in the Parcelles Assainies neighborhood. Needless to say, Diouf features heavily in this dissertation.

I’ve been fortunate to visit Dakar almost every year since 2012 until 2018 when I began my dissertation research, skipping only 2014. As an undergraduate in 2012, I traveled to Dakar to study French with a study abroad program through Washington University in St. Louis. During that six weeks, we were asked to conduct an independent research project, and while I wanted to study something about pregnancy, I didn’t think it was feasible, and chose instead to

look at the landscape of biomedical and “traditional” healthcare in the region. In the one of the last nights of our stay, unrelated to that project and over *ataaya* (tea) with a few other students and a couple of the *gardiens* of our apartment building, the conversation about our personal lives got raunchy. I recall a *gardien* remarking that he believed that if a woman swallowed semen, there was a risk that she would become pregnant. My classmates laughed and argued with him, but I was immediately interested in how he might come to think that. Where did he learn this? How was he sure? How did it affect his sexual practices? Was this a common belief among men in Dakar? I don’t remember if I ever got the answers I was looking for, but I left Dakar wanting to know more about what men thought about reproductive health and sexual behaviors, and I was determined to go back the following summer to start a new project - so I did. The following year, I conducted six weeks of ethnographic research for my bachelor’s thesis. The work consisted mostly of interviewing 12 men about their knowledge of reproductive health issues and sexual behaviors, but the data was largely gleaned from just spending time in men’s spaces - tea-drinking circles on the sidewalk, in cafes, at dance clubs, at construction sites - listening to them and watching the ways they flexed their masculinities through tales of masculine conquest, and inviting me to participate in conversations about gender roles and gendered labor, conversations that would eventually evoke all matter of media from American TV shows (my masculinity fell short far from Jack Bauer’s) to the words of the Prophet Muhammed. By the end of that year, I’d made so many connections among young, politically restless, underemployed, working class men, that I had a sense I could return to continue research as they might be getting married and settling down. I also knew that expectant fatherhood was a rarely studied subject (as detailed in the previous chapter) and thought that perhaps I could return to conduct that research within the social network that I’d already built. If only it was that easy.

While this project has been in the works since 2014, the 12-month period of Fulbright-Hays funded dissertation research was conducted from January to December 2018. It consisted of three phases: recruitment, interviewing, and case study, as well as participant-observation throughout the year.

	Men	Women	Totals
Question 1	19	22	41
Question 2	33	0	33

Table 3.1. Research participants who were surveyed with free-listing questions.

<i>Hôpital sud</i>	<i>Hôpital nord</i>	<i>Hôpital central</i>	Totals
12 women	10 women	10 women	32 women
9 men	10 men	8 men	27 men
1 chief physician	1 chief physician	1 chief physician	3 chief physicians
1 head midwife	1 head midwife	1 head midwife	3 head midwives

Table 3.2. Research participants who were formally interviewed (semi-structured) at least once.

<i>Hôpital sud</i>	<i>Hôpital nord</i>	<i>Hôpital central</i>	Totals
4 expectant couples	2 expectant couples	0 expectant couples	6 expectant couples

Table 3.3. Research participants who participated in case studies. These numbers do not include their friends and family members

For the first four months, I lived with Senegalese family members in the centrally located, middle class neighborhood *Liberté 6* while our new house was made minimally habitable, and then moved into our construction site in Parcelles for the latter 8 months of the year. My intent was to work in the maternity ward of a hospital, here referred to as *Hopital sud*, following an invitation from the *Medecin-Chef* who had somehow found me through Facebook. As I knew I'd be living in Parcelles, on the northern edge of the peninsula and there was hospital nearby, I chose to add *Hopital nord* as well. Eventually, my research assistants and I would add a third ward, *Hopital central*, to the research design for its unique service known as *accouchement humanise*, which I describe in Chapter 5. Work in the hospitals required close collaboration with

midwives and nurses who gave us access to patients and meeting spaces, but also gave us crucial insights and feedback on the work we were doing and what we were learning.

Work with expectant fathers might not seem like it demands such an emphasized engagement with maternity wards and their personnel, especially if you knew that men almost never enter those spaces, but it was an integral part of dealing with the challenge of conducting research on a subject that few people discuss openly. When I started looking into expectant fatherhood in 2014, even after I had seeded the beginning of a large social network of young men, it was nearly impossible to find expectant fathers. I had planned to seek them out through a sort of snow-ball sampling method of just asking around. “Do you know any men whose partners are pregnant? Give them my information.” And the answer was always *no*. I came to learn that this is simply because men don’t talk about their partners’ pregnancies, barely even to their closest friends. In most cases, even if you sort of suspected that your friend’s wife might be pregnant, you wouldn’t know for sure until the day after the birth when you’re being invited to the *ngente* or naming ceremony. In 2015, of the dozen or more men that I interviewed that summer, about half had no children, while the other half were fathers. By pure chance, one of the childless men was an expectant father, and none of his friends knew.

In designing research to look at expectant fatherhood, I had to be creative. With input from friends in Dakar, I devised and executed the following plan: recruit pregnant women in maternity wards, interview them about the care they receive from their family and friends, and, at the end of the interview, ask if we could interview their partners (or husbands) at another time. For the vast majority of cases, this strategy worked.

All of the interviews were conducted in Wolof, French, or Pulaar and audio recorded. My research assistants, Fatimata Abdoul Kane and Papa Babacar Sarr, were indispensable sources of

aid at this stage, where Fatimata recruited pregnant women and Babacar recruited expectant fathers. They transcribed and translated all of the Wolof or Pulaar interviews into French, which I then read over, coded, and annotated.

I had not anticipated that, while I had approval from the *Comite National d’Ethique pour la Recherche en Sante* (National Ethics Committee for Health Research, or CNERES) at the *Ministere de la Sante et l’Action Social* (MSAS, the Ministry of Health and Social Action) to conduct my ethnographic dissertation research in hospitals in Dakar, I would still need to get approval from the hospitals themselves. This required going to meet with the *medecin-chefs* of each hospital, where they would tell me I needed to get approval from the *medecin-chefs* at the District Hospitals under which their facilities fell. Those *medecin-chefs* passed me on to the Regional Medical Office of Dakar, under which - thankfully - all of the districts fell. In essence, I had learned about the map of medical bureaucracy backward. Once I had approval from the Regional Office, I went back to the District Hospitals for approval, and then delivered those to the local hospitals and asked for their approval. While this multi-week ordeal went on, I worked with Fatimata and Babacar to conduct free-lists until we could begin recruiting participants and undertaking participant-observation in the maternity wards.

One of the foundational approaches to my research is the acknowledgment that “care” is a locally-situated concept bound up in expectations about social, economic, and gender roles. Before we could begin asking questions about men’s experiences of expectant fatherhood, it was important for us to first establish what was meant by “men’s involvement.” We conducted free-list surveys of 41 individuals - 19 men and 22 women - asking to name all of the ways that

someone could take care⁶ of a pregnant woman. We asked in this implicitly non-gendered way so that we could later ask interviewees to pile-sort the responses by gender.

Many of the 287 responses were unique. My research assistants and I then took the responses and grouped them into themes for an easier analysis⁷. For instance, one response was “make sure she gets an HIV test” (a normal part of prenatal care) while another was “make sure she’s not smoking cigarettes.” I suggested to the assistants that we might create a grouping called “watching her health,” and they agreed. Overall, the grouping exercise went smoothly, but having Senegalese assistants was particularly useful when I had difficulties distinguishing between acts of *yërmande*, *muñ*, and *comprehension* - pity (roughly), patience, and understanding. In the end, we grouped the responses into 26 themes.

Using the Excel extension FLAME v1.2, we were able to develop a Smith Index of the themes. A Smith Index tells us which themes (by virtue of their constituent responses) were mentioned most frequently and ranked highest (i.e. mentioned earliest in the free list). They are:

1. To provide emotional support
2. To be attentive
3. To encourage her to go to her CPNs
4. To watch her health
5. To help her do her tasks
6. To give her food
7. To watch her nutrition
8. To go with her to her CPNs
9. To give her advice
10. To give her money for her CPNs
11. Understanding
12. *Yermande*
13. To provide financial security
14. To go on walks with her
15. To have sex with her
16. To buy her medications
17. To show her physical affection

⁶ *Prendre soin* in French, *faj* in Wolof.

⁷ While I know of no example in research methods literature of this kind of grouping, I do see it as a sort of “data scrubbing.”

18. To be present for the labor and delivery
19. To make sure she wants for nothing
20. To protect her
21. To find her appropriate clothing
22. To find her a gris-gris
23. To have faith (in Allah)
24. To encourage her to do physical activity
25. Preparations for a new family member
26. To pay for the birth

After analyzing the free-list exercise, we still hadn't received clearance to begin research in the maternity wards, so we did a second free-list, this time asking 33 men a purposefully vague, "How do men in Dakar prepare themselves for fatherhood, before, during, or after the pregnancy?" We received 211 responses which we organized into 21 themes. The themes were organized by Smith Index as follows:

1. Developing social responsibility
2. Learning to father through socialization
3. Formal education
4. Get married
5. Becoming a provider
6. Having faith (in Allah)
7. Saving money for the *ngente*
8. Taking care of one's partner
9. Discussing the desired number of children with one's partner
10. Being the *borom keur*
11. Saving money for the wedding
12. Watching the child's health
13. To protect one's partner and child/ren
14. Informal education
15. Saving money for the birth
16. Learning to be happy and satisfied
17. Considering birth spacing
18. Retirement

We did not conduct this second round of free-lists with the intent of conducting a pile-sort exercise. Nonetheless, we learned a great deal from it; fundamentally, in both cases, we learned how people talk about and conceptualize these topics. What was remarkable to me was just how much my Senegalese research assistants were learning, as the topics of pregnancy and

parenthood are not freely discussed. In both cases, the free lists informed how we would proceed with the construction of the interview instruments, particularly in what questions we would ask and how we would phrase them.

Normally, when constructing a pile sort exercise, one takes the top 10-20% of the responses based on their Smith Index. With 26 groupings (in the first free list), we would have had to choose the top five, which we didn't believe would help us determine what kind of gendered division of prenatal care our participants envisioned. Categorizing the responses into themes was not intended to give way to pile sort cards anyway, it was a way of scrubbing the data for a cleaner analysis. We therefore selected 64 of the original 287 responses (22%), weighted against Smith Index depending on which category we had grouped them into. During semi-structured interviews with pregnant women and expectant fathers, we asked participants to organize the 64 cards into three groups with no direction of how they should be organized, and then we photographed the three groups. We then asked them to reveal why they organized the cards the way they did. If they did not explain that the tasks were organized by gender, we would then ask them to repeat the activity, but this time into categories of tasks women do, tasks men do, and tasks everyone does.⁴

After completing the free-list exercises, we were ready to begin recruiting at *Hopital sud*, and then *Hopital nord*, and later *Hopital central*. Initially, we wanted nurses and midwives to refer pregnant women to us at the end of their *consultation pre-natales* (prenatal appointments, or CPNs). This required the junior midwives (who do the bulk of CPNs) to explain to women that there were researchers who would be interested to talk to them about pregnancy, either in an

⁴ The exercise was such a burden on the participants, my assistants, and me that we abandoned it after 34 interviews, reasoning that we probably wouldn't learn anything new after that. The pile-sort data remains unanalyzed.

adjacent room or reachable at a phone number (in the case that we were not present). In practice, the junior midwives either forgot to say anything at the end of the consultations or did not feel they could explain the research clearly enough (which they were not required to do), or the pregnant women simply did not call. Madame Wane, the head midwife at *Hopital sud*, suggested that she should just directly call pregnant women. Once she understood that we were looking for women in their first trimesters, she pulled out a large patient registry of names, phone numbers, and approximate addresses. The book was a record of their most recent and next appointments and their approximate conception date. Mme. Wane, a charismatic older woman, started by calling four women that she had recently seen, greeted the women warmly, asked how their families were, and then explained that a *tubab* was interested learning more about pregnancy in Dakar, but that the interview would be mostly directed by a Senegalese woman in Wolof (or Pulaar if necessary). In some cases, Mme. Wane would put Fatimata on the phone who would answer any initial questions and then, if the woman agreed, set up a meeting time and place.

Learning from this experience at *Hopital sud*, we knew not to ask nurses or midwives at *Hopital nord* or *central* to refer their CPN patients to us. The maternity ward at *Hopital nord* was perpetually packed with pregnant women, their *accompagnant*, and sometimes a small child or two each sitting on old chairs riveted to the floor or ceramic tile benches protruding from the wall - if they were lucky enough to find a seat at all. The head midwife there, Madame Gueye, was very much interested in our work and would have liked to help as much as Mme Wane had, but we also understood that she was overworked and understaffed. She had accumulated four months of paid vacation over five years that she refused to take. "If I leave now, this place will collapse." Unlike at *Hopital sud* where I rarely waited to see Mme Wane, waits at *Hopital nord* for Mme Gueye could last hours. After our initial meeting, while she ate what she could between

CPNs, she gave us a recovery room that we could use for interviews whenever it was available and directed Fatimata to simply approach pregnant women and ask them if they would speak with us. We were on our own.

Finally, when we later added *Hopital central* to the research agenda, we came to know Madame Gassama. Like Mme Wane, she was charismatic, wise, and gave me a hard time about my Wolof. She had worked with *tubab* researchers before, so she was familiar with what I was up to. Like Mme Gueye, she was very busy, though for different reasons. In 2014, the Japanese governmental organization JICA (a sort of USAID analog) flew her to Japan to train in *accouchement humanisé* (AH) with the understanding that (1) the Senegalese government would support the practice of AH in Senegal and (2) that she would train others. As the only midwife in Senegal to participate in JICA's training program, she was teaching AH at the state nursing school and training new midwives in AH at *Hopital central*.

Semi-structured interviews were conducted with expectant fathers, their pregnant partners, influential male and female kin, and healthcare providers. Ultimately, we formally recruited 78 individuals. Of these, 32 were pregnant women and 27 were expectant fathers, as not all men agreed to be interviewed after we had already interviewed their partners. The remaining 19 individuals were *medecin-chefs*, midwives, nurses, employees of MSAS and non-profit organizations, and, during case study follow-ups, relatives or friends of the expectant couples. Expectant parents were interviewed about their experiences during the pregnancy, including but not limited to the ways in which the man engages with her pregnancy. Male and female kin were also interviewed, partially employing a person-centered technique (Levy and Hollan 2015) to reveal local perceptions of the differences between what is socially expected and what is personally practiced with respect to care and masculinity broadly and led to questions about the

motivations that men might have for engaging with pregnancy in expected or unexpected ways or how those practices change over time. All interviews inquired about certain indicators that were to be used to assess roughly what drives men to participate; these indicators included, but were not limited to, age, religion, employment status, occupation, income, access to public or private healthcare, education, marital status, whether monogamous or polygamous, the number of children or previous pregnancies, presence or absence of kin relations nearby or abroad, whether one grew up in a rural or urban environment, and knowledge of biomedical prescriptions of maternal and child health, attitudes about safe sex and condom and contraceptive use derived from media, social networks, or experience from previous pregnancies. Expectant mothers and male and female kin were interviewed about what they understood to be driving men's engagement or disengagement and how they might promote or discourage such engagement. Healthcare providers were also interviewed about how they view and interact with men's participation.

As is the nature of participant-observation, an untold number of informal interviews (i.e. conversations) related to the research were had with many of our participants, as well as our own family members, Senegalese professional colleagues, friends, and neighbors - though the number surely exceeds the number of formal semi-structured interviews undertaken. Participant-observation – the technique of paying attention to and taking part in local practices, conventions, and interactions (Musante 2015) – was undertaken in all three maternity wards, research participants' homes, men's gatherings, and religious and life cycle celebrations (i.e. births, baptisms, marriages, funerals), and other unanticipated opportunities for the extent of the research period. This method illuminates insightful contextualizations of interview data, some of which focus on the ways that women or healthcare providers encourage or discourage men's

engagement. As a resident of Liberte 6 and Parcelles, and a daily visitor to Medina, I was involved in daily routines and social interactions with men and women of all ages. This experience provides an intimate understanding of expected masculine practices and ways of speaking, but also current and local events, pop culture, daily struggles, and small victories, which create the broader context of specific research data.

After the initial round of interviews was done with each pregnant woman and expectant father dyad, we developed a list of likely candidates for following as case studies. At that point in the research timeline, the pregnancies that had not been terminated would have been about 4-6 months along. Cases would include, ideally, the expectant couple and two family members from whom they receive relationship and parenting advice. The case study would involve one follow-up interview with the expectant father, one interview with the couple together, one interview each with the two relatives, one followup interview after the termination of the pregnancy, and - *insh'Allah* - an invitation to the *ngente* where we could meet other relatives, offer our blessings and gifts, and participate in the celebration.

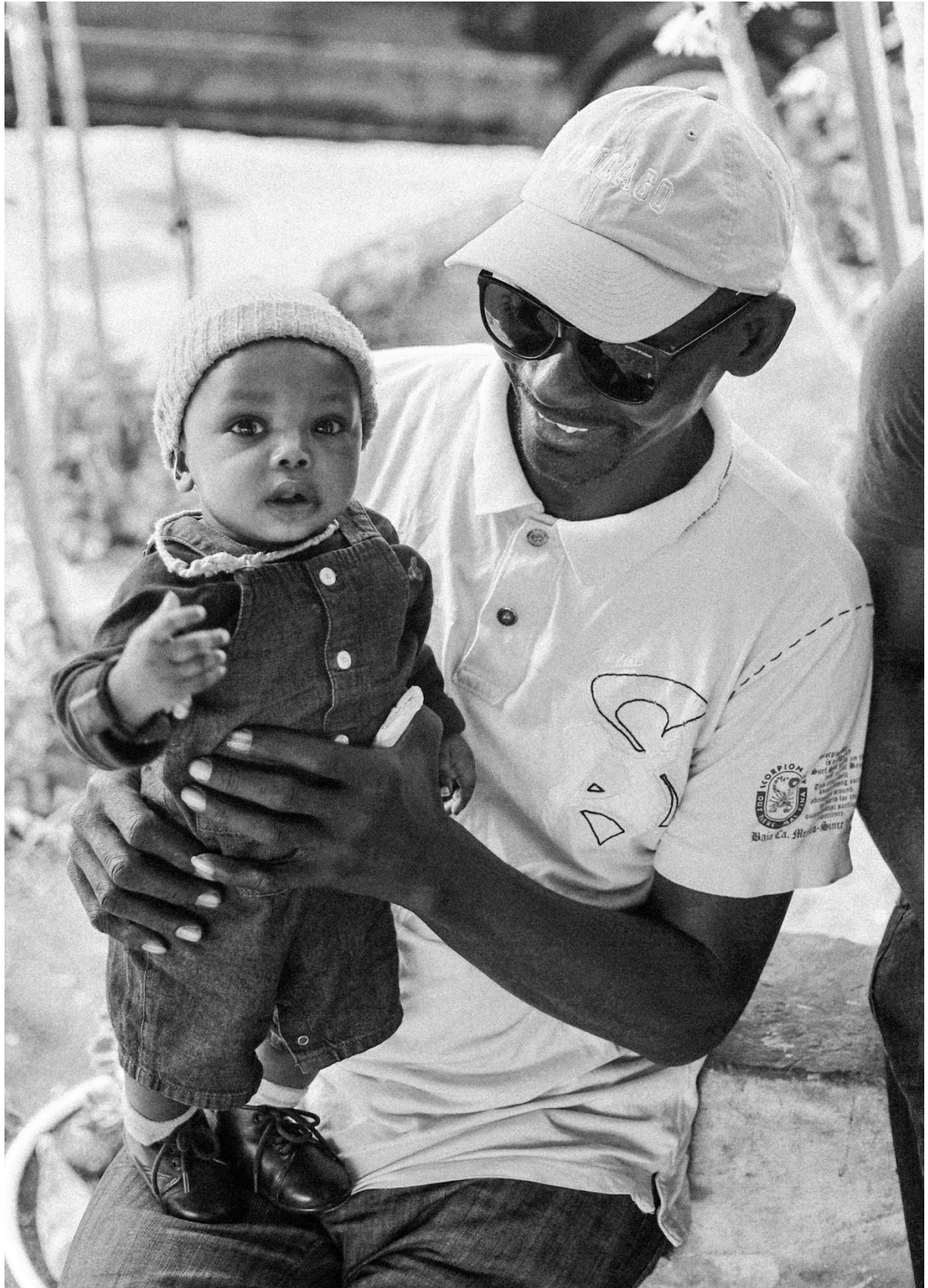
Follow-up interviews with men and their relatives centered their life histories. Life history interviews included topics such as their own childhoods, relationships to their parents and siblings; desired and actualized marital status; and gendered expectations. The purpose of these interviews is to explore how men understand their engagement with pregnancy and childbirth, including how their views and experiences are shaped by their parental-care-receiving histories. These interviews also make apparent the changes in generational attitudes with respect to men's engagement, and highlight political, economic, social, and religious contexts that are significant to the interviewee.

Early in the year, I had the opportunity to guest lecture Babacar's English course at Lycee Maurice Delafosse. The 12-16 students, mostly men, were mostly young Senegalese people from the immediate area - Medina, Gueule Tapee, and Fass - though some had come from rural Senegal as well. They were mostly interested in pursuing careers in business or traveling for education in the UK or United States. Each opportunity I had to teach, I led the class in discussions around family and parenting, im/migration, and - at Babacar's insistence - corruption. In one case, I challenged the class to reflect on why the few women students taking the course had such irregular attendance which revealed a great deal of local context about gender, labor, and disparities in education. All of these moments served as informal focus group discussions about how these individuals considered political and social issues and provided important (if somewhat crash course) for the issues that I was thinking about at the time.

All focus group, life history, semi-structured interviews, field notes, government- and non-profit-issued educational materials, YouTube clips of news stories, and photography were transcribed, translated to French (if conducted in Wolof or Pulaar), and coded using MaxQDA12 as they were collected. Recurrent themes, words, and phrases concerning the research objectives progressively produced a codebook (Miles and Huberman 1994) by which codes were cross-referenced to determine what kind of themes were discussed adjacently with each other. Ongoing analyses informed semi-structured interviews and conversations throughout the research period in a sort of loose method of grounded theory.

These analyses served as the basis for synthesizing three kinds of narrative. First, individual case studies are narratives that rely on key interlocutors' experiences of direct and indirect participation prenatal care. The analysis of data derived from all collection methods describe men's attitudes, practices, and possible changes throughout the pregnancy and theorize the

factors in men's lives that influence their participation, such as demographic variables, notions of socially acceptable gender practices, the needs of the pregnant partner, interactions with healthcare providers, or advice from or examples set by senior kin. Second, data analysis also contributed to a description of intragenerational variation. Drawing from free-list and pile-sort exercises, semi-structured interviews, and key interlocutors, I looked at the motivating factors (e.g. employment, education, marital status, religiosity) of variation within generations. Finally, my analysis describes intergenerational change: the ways in which local ideas about gendered practices, expectations, and space may differ between expectant parents and their senior kin, signaling a generational shift. This analysis makes use of free-list and pile-sort exercises, semi-structured interviews, life history interviews, and participant-observation with attention to how *and why* men participate in prenatal care. All analyses and narratives were ultimately aimed at describing men's experiences of and participation in prenatal care, situating the experience of expectant fatherhood into broader notions of masculinity as well as global, state, and NGO healthcare trends, building upon anthropological theories of gender masculinity, and theorizing gendered space. In the end, as you'll see, it turned out to be even more complicated.



Chapter 4: Walk, Work, and Worry: The Materiality of Men’s Prenatal Care

Xamxam dafay weey, xaalis d’ay jeex.
(Knowledge remains, money gets used up.)
– Wolof proverb

In this chapter, I explore the social roles of expectant fatherhood in Dakar, Senegal and how the material environment of prenatal care is inextricable from the social environment of prenatal care. Here, I draw on the thoughts of John Law and Annemarie Mol (1995) who argue that materiality and sociality are interdependent, but I also demonstrate that not only are environmental conditions co-constructed, so too are the outcomes. Expanding upon the conception of Law and Mol’s formulation makes space for the *material* consequences of *social* labor which, in this case, is illustrated by the emotional support that expectant fathers provide. Additionally, I want to highlight the Wolof concept of *yërmandé* as a precise and self-contained example of how materiality and sociality co-relate and co-produce each other.

In their notes on materiality and sociality, Law and Mol argue that “the social isn’t purely social” (1995: 276), that the material is always in conversation with the social, a co-construction that precludes the existence of anything firm or stable because everything is always the result of that relationship. This is evident in the *entourage* – a tightly knit network of women and the expectant father who surround, surveil, and protect a pregnant woman from all kinds of harm, worldly and mystical. The *entourage* includes mothers-in-law (*goro*), sisters-in-law (*njèkk*, also called “the female husband,” or *le mari féminin*), close friends and cousins, and, of course expectant fathers. To a lesser degree, social support can include neighbors and state-trained “neighborhood-aunties” (*bajenu gox*), vendors, taxi drivers, nurses, midwives, physicians,

pharmacists, and so forth. (Midwives are sometimes considered part of the entourage, though not always.) A pregnant woman is, then, in relation with all of these actors on a day-to-day basis, but she is so *differently* in each case. She seeks affirmation and emotional support from her loved ones, she looks on strangers with suspicion, she develops new relationships with medical and spiritual professionals. She is also *related to* (protected, looked at [or not], revered, placated, accommodated, cared for, spoiled, belittled, pitied, understood [or not], patronized, condescended and mansplained to) differently. These new relationships or reconfigurations of old relationships arise precisely because of the biological aspect of pregnancy itself. Pregnancy signals to others that the conditions of her health and well-being and needs are different than usual (and often from their own), and the way she is differently-related-to has direct effects on her health and well-being and that of the fetus. The biology is therefore in relation with the sociality, and when scholars focus on only the body (or bodies, both maternal and fetal), much of the fuller picture is obscured.

Simply put, without a pregnancy an entourage could not form. But when looked at in depth, the assemblage of social and material relationships that constitute the entourage are seen to be much more complicated. The overreliance on a biological view of health and healing has real-world consequences in global health campaigns (cf. Hörbst and Wolf 2014). Ethnography allows us to deconstruct this relationship in a way that reacquaints stakeholders in state-run health institutions and global health workers, researchers, and policymakers with the nuance of prenatal care networks in Dakar. If we think about pregnancy in Law and Mol's terms – that materiality and sociality are always co-constructed and in relation with each other – we are forced to see the connections between biological pregnancy and the social fabric that surrounds it.

To demonstrate a narrower context of interdigitated sociality and materiality, I attend to men's narratives almost as much as I do to those of women, while analytically, men's narratives tend to be emphasized as much or more. In this chapter, I look at successes and failures of what Dakarais midwives call "the most important job" in the entourage – for the expectant father "to find the money" (*sersé larzã*) – but also acts of emotional support. In this way, I not only highlight the *relational materiality* of men's prenatal care – that men are navigating economic and social pressures in order to make sense of newly incipient kin roles, particularly as it relates to "finding the money" – but also that men's emotional support (or lack) can produce material consequences for a pregnant woman and, potentially, her pregnancy.

An ideal dynamic between expectant fathers and their pregnant partners is one that mobilizes *yërmandé*. When I first encountered the word, I was told the translation was *avoir pitié* ("to have pity"), but I came to learn after deeper conversation with colleagues that the French translation is not adequate or accurate. "Pity," in English, may mean to be compassionate or merciful toward someone, but it has the connotation of looking down on someone with less power. In English, no one wants to be pitied or characterized as "pitiful," because it describes helplessness and weakness. In Wolof, *yërmandé* does include an aspect of pity, but the power relationship has less to do with the weakness and helplessness for which one has pity than it does the power of the one who pities to intervene. Weakness and helplessness are collapsed into a state of vulnerability, a state that is a better description for the kind of work that *yërmandé* does, as it interlocks with the second component: What is special about *yërmandé* is that it is as much a feeling of being called *to intervene* as it is a passive feeling of empathy. When someone says they "have *yërmandé*" (*am naa yërmandé*), what they express is that they recognize an unfortunate situation (to put it mildly) – e.g. discomfort, hunger, mood swings, labor pains, or

trauma, in the context of pregnancy and childbirth – and that they are compelled to find a solution that will end that person’s suffering. *Yërmandé*, then, is a self-contained concept about the co-production of materiality and sociality. This will become more relevant later in Cheikh and Fama’s story.

Introducing Cheikh and Fama

Cheikh and Fama, both in their forties, were married in 2005. They have a lot in common: they each have 4 children from previous marriages, both marriages lasted a decade, and they both share great-grandparents. This last point is important because Cheikh refers to this to explain why they have a reputation among their family and neighbors for picking fights with each other. If you ask Cheikh why they fight so much, he’ll tell you, “She’s my little sister,” effectively meaning they’re *too* close – they grew up together – a sentiment that blurs the meaning of closeness across intimacy and kin-relation. What we came to find, however, was that Cheikh and Fama had already suffered through two miscarriages and, during this new pregnancy, Cheikh was taking up a position of emotional distance from Fama, while at the same time maintaining close surveillance over her and their unborn child’s well-being. Fama was frustrated that Cheikh seemed apathetic about her emotional well-being but was still significantly financially and mentally invested in her health. This made for an incendiary dynamic between the two of them.

It didn’t help that Fama felt that her *entourage* was handicapped by the loss of her mother, an important figure in prenatal care. “Right now, my primary problem is that my mother isn’t here. She’s deceased. She used to do everything for me when I was pregnant.” She took charge of finding Fama’s *gris-gris* – a magical charm with protective properties – and many other things in Fama’s first few months of pregnancy. “Now, without her, I feel inexperienced,

like I don't know anything about pregnancy, even though it's not my first time." She once remarked that after not having had any children for 13 years, her body has changed, so pregnancy affects her much differently now. She is exhausted, she has insomnia, she has little or no appetite, she has a great deal of nausea, and she has eight children to care for. "It's like I'm pregnant for the first time all over again." In many cases, the *entourage* is composed of a number of women in addition to one's mother, including aunts, sisters, and in-laws, who give advice about how to comport oneself during pregnancy and concern themselves with more personal obstetric issues as well. Without Fama's mother, these other women ideally should step in to take up her role, but given the couple's history of pregnancy loss, Cheikh had effectively taken the lead, stepping in to keep a watchful eye over everything. Nonetheless, his lack of first-hand experience as a pregnant person precluded him from giving certain kinds of experiential advice and understanding, thus Fama still felt that she was lacking effective interpersonal care.

When my assistants and I first met Fama at *Hôpital du sud*, she was in her first trimester. The maternity ward at *Hôpital du sud* is relatively small and the floor and walls are tiled and spotless. A dusty public health poster shows illustrations of heavily pierced and tattooed punk rockers and warns patients about the risks of contracting Hepatitis B from body modifications. Unlike other public hospitals, the ward here can be slow – even empty at times – as well as cramped full of women waiting on a variety of exams and consultations. The area of the waiting room is almost as large as all of the consultation rooms combined. Chairs are riveted to rails like a bus station and line the floor in rows. There is a small CRT television with a fuzzy picture hanging high in the corner of the room playing an American film I've never seen. The air is thick with humidity. Young women hold babies, older women fan themselves and their juniors with

öppukaay (plastic or grass-woven hand-fans). There are no men – this time. Fama was there with her aunt.

Fama found out three months prior that she was pregnant. “My sister had prepared chicken for dinner and brought it into my room, and the smell just hit me. I was instantly nauseated. I thought, ‘Wow, that’s not normal.’ I went and bought a [pregnancy] test, and it turned out positive. To tell you the truth, I wasn’t very excited about the news, because I didn’t want to have another child under these conditions. I wanted to put together some money first so I could raise and cherish it first and I didn’t want to lose my job. I wanted another child, just not at this time!”

Fama told us that Cheikh was very excited about the news, but Cheikh later told a different story. “I didn’t jump for joy, I didn’t smile, I didn’t do anything. I said thanks to Allah, that was it. I didn’t want a repeat of what had happened twice already.” The previous two miscarriages had devastated him. During their first pregnancy, he spoiled Fama with gifts and affections. He was relentless. During their second, he tempered his enthusiasm as not to get his hopes up, but she says she still felt spoiled by him. Just before this third pregnancy, Cheikh was planning to buy two new phones for the both of them, but when he found out she was pregnant, he held off. He’d been through this before, and he knew that money would be tight in the coming months. After three days, he decided to buy her a new mobile tablet instead and save the rest of the money for the imminent expenses of pregnancy. He was resolved to remain cautiously optimistic: he would do everything he could for her health but try to shield himself emotionally.

Here, we see materiality and sociality come together in different ways: Cheikh’s lack of embodied experience of pregnancy and desire to be involved pushes him into roles that he’s

better suited for and more familiar with. He's best at budgeting their finances and, as we'll see later, reinforcing state surveillance of her health (a topic further discussed in Chapter 6). By providing Fama's material needs (e.g. a *gris-gris*) and desires (e.g. a tablet), Cheikh demonstrates of emotional support through the performance of protection and morale-boosting, respectively, and security overall.

It is also important that while Cheikh demonstrates an understanding of the profound gravity of his role in making sure that Fama is adequately cared for, he also is clear about his own emotional restraint. Their history of pregnancy losses had material consequences in the form of significant financial and emotional investments in pregnancies that would never come to fruition. So too did they have social consequences, expressed by both Cheikh and Fama as disappointment and sadness, but we may also speculate from other couples' losses (in Chapter 8) that they both probably suffered periods of depression following the losses, and that because of his role as a masculine (i.e. emotionally durable) provider, Cheikh probably had to downplay his disappointment in order to take care of Fama. As a result of these experiences, Cheikh is conditioned to not get his hopes up.

Additionally, while it might seem vulgar to speak of "investments" in pregnancy, it's clear from the way Cheikh and Fama both talk about the pregnancies that they both have different perspectives on this. While Cheikh believe he is maintaining the same level of financial and emotional involvement has he had in the past, Fama feels like he dropped the ball. She says he's not as attentive as he was in the past. Even if he was, it's still not enough to make Fama feel like supported in the way that she needs because he lacks the embodied experience of pregnancy.

Technological Anchor Points

Cheikh and Fama live near the beach in Medina. In the final trimester of the pregnancy, Cheikh invited Babacar and I to rendezvous with him there. There is a theme park there that overlooks the ocean. On the edge of the park, just outside the property line, is a little beach where residents go to swim, bathe, and eat fresh seafood. Along the wall that separates the park from the beach is a row of small tents crafted from plastic mats and tarpaulins. Cheikh has reserved one of these for us to get out of the sun but the three of us huddled together in that space did little to cool us off. Neither Cheikh nor Babacar are sweating in this heat, but I opt to buy us all ice-cold soft drinks anyway.

Cheikh is about 6 feet tall, wearing a Nike baseball hat, blue jeans, and a t-shirt. He removes his hat for a moment to reveal a shiny scalp. His sideburns and short, trimmed beard outline a big toothy grin, and he greets me in a boisterous, almost Parisian-accented French. “This is where I come to get away,” Cheikh tells us. “I just look out onto the ocean and think about things.” Cheikh works for the *gendarmerie* (municipal police) in Dakar. He comes from a military family and spent his early years moving all over Senegal with his father. “My family is an army family. They were all soldiers.” He wanted to join up too, but he thinks it would’ve limited his personal goals. He was more interested in travelling abroad for work, which still hasn’t panned out.

Cheikh has strong ideas about his experience of expectant fatherhood in comparison to his *tubab* (in this context, “white”) counterparts, no doubt drawn from his expatriated friends and family members, as well as Euro-American TV shows and films. “I’m not like the whites, you know. I don’t go and buy things for the baby before they’re born.” He pauses. “Well, with the technology [ultrasound], I do like to know the sex of the infant before the birth so that I can prepare myself [mentally].” Cheikh is intrigued by sonograms and how midwives can tell the

position of the fetus. “You know, if the baby is breech (*venir en siege*) and it’s not turning, a woman risks having a c-section! It’s not normal, and it can be a little catastrophic for her.”

Cheikh learned this while accompanying Fama to her last prenatal visit (*consultation pre-natal* or CPN) when the midwife-sonographer found that the baby was turned. Fama was instructed to just take it easy and hopefully everything would work itself out. They were scheduled for another sonogram shortly after this meeting on the beach, but they have to delay it for a few weeks until after *Tabaski* – there’s just no money right now. “She’s always given birth normally... We can do a c-section if we have to, but God could ensure that the baby is born normally too. I’m actually really afraid that it could be a c-section though.’

It is unremarkable that Cheikh was in touch with his emotions as much as he was. Being able to identify and discuss your feelings isn’t particularly noteworthy among the Senegalese men I’ve known over the years. Self-care – going to the beach to look out onto the ocean and meditate on life – is a material/social outcome of, in this case, strained relationships and overburdened emotional bandwidths. The sights, sounds, and smells of the beach, the camaraderie, the shared beverages, and the food provide relief and renewal for Cheikh as an expectant father. For him, he deserves the escape because he sacrifices so much. He wanted to join the military but put it off because he wanted to work abroad. That’s not likely because he still has small children at home (and another one on the way). His adult children are men, so they aren’t doing the care work for younger siblings that they would do if they were daughters. His stated refusal to go abroad (though I suspect he is unable) is a condition that produces material consequences (a difference in income, though no one could say if it’d be more or less) and social

consequences (his immediate presence in the family). He is torn between these imaginings of what is and what could be, and that discomfort is part of what sends him to the beach.

Reproductive technologies give Cheikh a more reliable vision of the future in this foggy, unknowable period of his life. Cheikh's interest in the sonogram and the c-section is yet another co-construction of materiality and sociality. He is explicit that his desire to know the sex is not so that he can go and buy things before the birth, "not like the whites" – a space in which the co-construction of materiality and sociality can be dangerous. Generally speaking, purchasing goods for an unborn child is a presumption of a positive birth outcome and neonatal survival. For the more ardent adherents to their spiritual leaders, such an act could represent an invitation for not just misfortune (*malchance, mauvais oie*). In Cheikh's case, his experience just tells him that it would be a risky financial decision at time when he needs to spend his money wisely.

Cheikh wants to know the sex, he says, so that he can mentally prepare himself. Men in Dakar, whether they have children or not, widely consider daughters to be more difficult to raise than boys because there is a perception that they demand more care, protection, discipline, and resources. Additionally, as daughters grow up, they are socialized in numerous aspects of "women's business" (*affaire u jiggeen*) that men cannot teach, at least in cases of some forms of domestic work (e.g. cooking) and the body (e.g. pregnancy). Fathers (expectant or otherwise) always say "it doesn't matter" if they have a boy or girl, but there is usually a sharp relief at the birth of a boy.

But in the process, Cheikh learns other things from the sonogram as well. The sonogram and the sonographer have something to tell Cheikh about this specific pregnancy that he can then use to enforce proper prenatal care, according to the *carnet* – a pregnancy guide and medical record given to all pregnant women in state hospitals in Senegal (which is further discussed in

Chapter 6). What he learns from the sonographer expands his knowledge base of pregnancy and provides new tools for providing care, even if he doesn't fully understand how it all works. Fama was told to rest. Cheikh will see that she does – and he might have anyway – but he now has new motivations to make sure she does and he can share those motivations with her. The materiality of diagnostic sonography depends on social action of care to maintain a positive condition or avoid a negative outcome – or else why do it? In this case, Cheikh is aware that the social failure of adequate prenatal care could translate into the material outcome of a c-section. (It is doubtful, however, based on their history of loss and others' stories of trauma, that he would see it as *his* failure to provide adequate care.) It's not clear why Cheikh would fear a c-section, but at the very least I would speculate that the prospect of an invasive surgery is terrifying. Given his interactions with midwives and his deployment of medical knowledge (at one point, he talks about episiotomies), it would not be surprising if had he also learned about the myriad benefits of vaginal birth (not least of which might be the cost in comparison to the costs associated with a c-section). What is important is that for Cheikh, a c-section is to be avoided, and he will, within his power, do what he can to make sure it is.

Disruption

Cheikh's contributions in favor of a positive outcome are significant. In addition to doing what is expected of men in his position – finding money to pay for food, consultations, taxi rides, prescription medications, the coming hospital bills – he is resolved to make sure that God is pleased with him too. Normally, the *kilifa* (or head-of-household) is expected to sacrifice a ram on *Tabaski*, just as, in the Koran, Ibrahim sacrificed a ram in the place of his son. Cheikh opted for two rams. "I don't know if it's going to work or not, but I bought two rams so that God

would help me – so that *this baby* will come.” The grand total for two rams: 340.000 CFA [about USD \$550].

Despite these sorts of the financial and spiritual investments, Fama doesn’t feel like Cheikh is doing everything he can for her. Emotional labor – *comprehension* (understanding), *yërmändé* (compassion and empathy), and *muñ* (patience or endurance) in particular – is a key feature of meaningful social prenatal care, particularly in cases such as Cheikh and Fama’s in which kinship and hardship – relationality and loss – are at the foundation of their experience.

“He doesn’t understand me at all!” Fama says during an interview with the couple. “He annoys quickly! I don’t receive any understanding from him, and to tell you the truth, I’m pretty bitter about it. When your wife is in these situations [i.e. pregnancy-related mood swings] and you see her state, you have to leave the house, let it be, and come back after you calm down.’

“When a man raises his voice, his wife needs to shut her mouth,” Cheikh responds. “He doesn’t need to understand anything. He doesn’t need to leave the house. If the man goes out, that means that it’s the man who has shut his mouth and it’s the wife who governs.”

The exchange is heated but it comes back around the pregnancy. “I like that Cheikh takes care of my prescriptions and things, but I also think he’s more interested in the pregnancy than in me. If it was just me, I think he wouldn’t be so invested, but I’m carrying his child, so he does everything to the letter.”

“Her health comes before the health of the child, as far as I’m concerned,” Cheikh pushes back.

“If my health isn’t the best, the child’s health won’t be either. If I’m sick, the child is sick. So yeah, he’s going to say that. Before I was pregnant, if I told him I was sick and I needed a paracetamol, he would tell me to wait. Now, if I tell him that, he stops what he’s doing and

goes to find it for me. If I tell him I even have a headache, he wants to take me to the hospital. Before the pregnancy, he would tell me that it'll go away. Men only think of their children.”

Fama’s late mother once told her that her husband should be present for the birth “so that he can see your true value, so that he can see that you matter, and so that he will have *yërmandé* (compassion and empathy) for you for the rest of your life.” She continues, “If men had to see what we endure, they’d respect us more! I think that men don’t understand what pregnancy means. I want to *make them* see it and live it, even just that one day.”

Babacar is visibly uncomfortable with the idea. “So you want men to feel that pain?”

“From months one through nine, you live with pain,” she says. “Men need to know that pain!”

In past interviews, Cheikh has even provided bona fides for his courage in the face of trauma. “When I was a *gendarme* (police), I saw a charred body and I’ve seen a man hanged. I’ve seen a man run flat over by a car and killed. That didn’t faze me. Giving birth? That’s nothing!” At this point in the conversation with his wife, Cheikh is annoyed. “I [do] have *yërmandé*. Men already know what women endure. I want to be present [at the birth] to give her courage and strength and also know what the nurses are doing.”

Many of the men we spoke to felt nurses and midwives were notoriously negligent. It was shockingly common to hear men discuss midwives ignoring patients as they traversed waiting rooms from one office to another while staring down at the phones. I always suspected this was a performance, like wearing headphones in public so as not to be bothered by strangers, but in either case, many men were telling us, “They’re always on their phones!” Cheikh and Fama were deeply concerned about the professionalism and attentiveness of the hospital staff when it came to the day Fama would deliver. They planned to go to the military hospital where Cheikh had

connections through his job and family. “They’re uniformed men. They’re soldiers. Everything is very strict,” he says. “My aunt told me that we could go to a [private] clinic, but that’s expensive,” Fama offered. “Yeah well, your aunt is a little crazy,” Cheikh replied.

As I had anticipated, interviewing the couple together highlighted some of the conflict and disruption of their relationship in real-time, illustrating some of the more complicated ways of how materiality and sociality come together in significant ways.

While Cheikh is deeply invested in making sure that Fama does what is prescribed by the midwives and the *carnet*, that surveillance takes a backseat to faith when it comes to *Tabaski*. In the last portion of the vignette, we learned that Fama had a CPN scheduled after that interview, but that it would need to be delayed because Cheikh could not afford to both finance her CPN visit and celebrate *Tabaski* in the way that a man is expected to. *Tabaski* is one of the biggest holidays of the year. In addition to purchasing, caring for, and sacrificing a ram, the *kilifa* is expected to purchase extravagant foods, tailored clothing, gifts, and other needs for his family for that day. The working class men I worked with very often do so by drawing from senior, extended, and expatriated family members who can afford to give a little. The sacrificial ram is the most important purchase, so falling short on the other expenditures can be excused, but to not have a ram at all would be a great shame – it reflects poorly on one’s masculinity as a provider and as a Muslim. All costs around *Tabaski* must be cut, even a CPN, which many people in my research agree is one of the single most important things that a woman can do during pregnancy for her own health and the health of the unborn.

Cheikh is not delaying the CPN because he cares more about his reputation, however, but precisely because this *Tabaski* will revolve around the pregnancy. Cheikh’s sacrifice of *two* rams

is plea to God, at great financial cost (and risk), to let “*this baby* come.” It is a material demonstration of what we already knew – that he doesn’t take a positive outcome for granted – and what Fama has just told us: that Cheikh really wants this child.

I am unaware of what Fama thinks about this unusual financial decision, but it seems that it could contribute to what she already believes about Cheikh prioritizing the health of the fetus over her emotional well-being. Fama knows that Cheikh knows that maternal and fetal health are linked, but she is unsatisfied because she doesn’t feel the *yërmandé* that he claims to have; he doesn’t recognize the relationship between her emotional support and fetal health. For her, the only way that he can truly understand what she’s going through is if he could experience pregnancy and delivery in his own body – *Men need to know that pain!* – or at least bear witness to the delivery. Cheikh’s response is to cite a list of atrocities that he’s already seen in his life, things that are far worse than delivering a child – *Giving birth? That’s nothing!* Taking Fama’s feelings as justifiable and legitimate, it seems that if Cheikh really did understand, she might feel more supported. On the other hand, it’s hard to say how she would feel about Cheikh if her mother were still around.

It’s worth pointing out here, too, that Cheikh not only rises to the challenge of being present at the delivery so that he can prove his *yërmandé* and provide strength and courage to Fama, but so that he can monitor what the nurses are doing. In this way, the masculine surveillance that the state draws upon through artifacts like the *carnet* has turned back on the state. Fama is the unit of analysis, as far as he’s concerned, so watching “what the nurses are doing” is obligatory if he’s going to monitor the health and well-being of his partner and unborn child.

All things considered, Cheikh would prefer that Fama give birth at a military hospital. The symbolic power of the “uniform” is juxtaposed against the “cell phone” here as gauges of professionalism. *They’re uniformed men*, is Cheikh’s way of arguing that military healthcare workers do their jobs, while the consistent references from Cheikh and other men to nurses’ cell phones is a reference to youth, inexperience, and negligence. The uniform and the cell phone are, in this sense, shorthand for a level of professionalism that triggers notions of faith, trust, and care. (And somewhere between the two, Fama’s aunt suggests that they consider going to a private hospital. As Cheikh’s response shows, that’s completely out of the question and beyond his financial abilities.)

The Labor Tour

Fama woke up feeling abnormally strong abdominal pains. They knew the due date was soon, so Cheikh and Fama hailed a taxi to go to the military hospital. When they arrived, they were told that the fetus had gained a lot of weight and Fama’s blood pressure was rising. In the retelling of this experience, the hospital was either unprepared or ill-equipped to service Fama’s condition, and so they were sent away.

From there, they went to *Hôpital central* and by the time they arrived, Fama was in even more pain. Cheikh tried to soothe her by letting her know that she was not alone, but she was inconsolable, and he became frustrated. “I told her ‘You could’ve told me to stay home, because I’m useless here. All I can do is say *massa* [an expression of empathy meant to soothe].” Cheikh and Fama both were surprised to find that the midwives there would tell them the same thing that they were told at the military hospital: the baby was too big and Fama’s blood pressure was too high. “It’s too risky,” they were told. They went home to rest.

That night, they left to try another smaller, unnamed hospital where they received the same news. They were told to try *Hôpital du sud*. Fama went while Cheikh left to head home for some things. The midwife at *Hôpital du sud* told her to try *Grand Hôpital*, which was not far. She was turned away there as well.

Cheikh came to find her there. She told him what the doctor had said – the same as everyone else, “The baby is too big, your blood pressure is too high, it’s too risky.” Cheikh wanted to go in to talk to the doctor.

“It’s your job to help people, to deliver babies, and save lives!” he told the doctor. “If something happens, it’s not you that’s responsible. It’s God! I’m a believer that everything comes from Him. She could die, our child could die, and that would be the will of God.”

The doctor tried to calm Cheikh, telling him they could discuss things politely. “If something bad happens to [Fama] or the baby because of the risks, I will have to answer to you.”

Cheikh pushed back, “No, I’m not like that. I believe in God and everything that will happen, I will be responsible for.”

The doctor relented. Fama and Cheikh were led to a consultation room where Fama received an injection. Cheikh didn’t know what the injection was. They were instructed to walk around the hospital in hopes that her labor might begin. By 4:00 AM, it still had not started. Another doctor told them to go home and rest until the injection took effect. “If you stay here,” the doctor said to Cheikh, “the cries and screams of the other women will traumatize your wife.” Cheikh agreed.

Back at their house, they couldn’t sleep. They lied awake in bed until the first call to prayer, just before 6:00 AM. Fama turned to Cheikh, “It’s time.” They left the house with Fama’s older sister. Anticipating that they would be told to walk around the hospital when they

got there, they decided to walk to the hospital instead. (It was only a few blocks.) They were admitted again for another consultation with the same doctor. He told them to keep walking, which they did until about 8am. They would come and go and come and go, and each time, the midwives would tell them, “It’s not time, keep walking!” Cheikh was very annoyed with this whole process. A much older midwife told Cheikh to just be patient. “Look, you can see her abdomen is dropping. It’s coming. It’s just a matter of time.” Still frustrated, Cheikh continued to walk with Fama through the crowded halls and open courtyards for another hour until the staff determined that Fama was finally ready. They returned to the maternity ward where Fama was taken into a delivery room. “The midwife told me I could see the birth,” Cheikh told me, “but I lost my courage. I had to go outside. I couldn’t handle the screams from the other women.” Cheikh got bored and went back inside, approaching the door to the delivery room, but her heard Fama’s wailing and recoiled. He returned to the bench where he had been sitting in the courtyard. Fama’s sister emerged from the waiting room, but she had no news. They sat in silence for a while and then she went back inside. Cheikh began to cry. “The stress...it’s something else. Why didn’t they know anything? Why weren’t they telling us anything?” He regretted not trying to get into the delivery room. “All of my courage just evaporated because I had so much *yërmandé*. I just kept thinking “She has one foot here and one up there,”“ he said, gesturing to heaven.

About 20 minutes later, Fama’s sister reemerged. Fama had given birth. Cheikh immediately asked what the sex was. While he had preferred to know during previous pregnancies, not knowing this time was a way of not getting his hopes up by imagining how he might parent this new member of the family. “It’s a boy,” she said. Cheikh began to cry again, this time turning away and covering his face to hide it.

Fama was brought out of the delivery room with the baby. They rested in a long communal recovery space where there was a row of beds – some empty and some where other women rested with their newborns. The baby was swaddled in a thin white blanket. Fama was exhausted and laid gently into an empty bed with her newborn lying next to her. Cheikh walked quickly to the recovery room to see them. “Are you okay?” he asked. She nodded. She peeled back the blanket so that Cheikh could get a look. He knelt over her and put his arms around the baby, thanking God.

Keep walking. The walking and the worrying go hand-in-hand. As long as she’s walking, he’s worrying. They check with the nurse or doctor every so often to see if the worrying can end. Surely, it’s time. *Keep walking.* Even when Fama is done walking – when it *is* time – the walking and worrying continues for Cheikh: anxiously pacing in the corridors with nagging uncertainty. He knows nothing, is told nothing. *The stress...is something else.* Pregnant women are thought to occupy a space in the interstices between the living and the dead – a phrase I heard countless times from countless people over the years. He so desperately wanted to be there for her, but Cheikh’s once proud, bull-headed courage – recalling his experience with hanged men and burnt corpses – collapsed under the weight of women’s cries. I don’t blame him and I certainly don’t question his *yërmandé*.

What interests me here is that this particular hospital has no facilities for “humanized birth” (*accouchement humanisé*) – the facilities that would have allowed Cheikh into the delivery room in the first place. In other words, Cheikh should have never been invited into the delivery room in the first place because there were other laboring women in there with Fama (albeit separated by thin blue and green curtains). Had they been at a facility where humanized birth

services were offered, Cheikh and Fama would have been in a relatively smaller room with a midwife and perhaps an assistant, and no one else. To my knowledge, there is but one state-run maternity ward in Dakar with those facilities – *Hôpital central* – where the Japanese government established a pilot program to train midwives in humanized birth. The pilot study has ended, deemed relatively successful with some needed improvements, and now midwives at other hospitals are just waiting for the state to begin renovating their wards with humanized birthing facilities, but the funding has stalled. Consequently, the lack of material resources translates downstream into Cheikh’s experience in which men who desperately want to support their laboring partners (and pregnant partners who want the support of physical presence and maybe a little shock-induced *yërmandé*) are denied that opportunity.

Conclusion

In this chapter, I have argued that not only are materiality and sociality co-constructed, as Law and Mol have argued before, but that they produce material and social outcomes in concrete ways. Cheikh’s experience (at least six times) as an expectant father has prepared him with an expertise about what to expect, how to “find the money” and other resources, and how to budget and call upon those resources when needed. It also positions him to believe that he can take over the role of Fama’s late mother in the entourage and that his *yërmandé* in that role will be enough for her. This may be no better demonstrated that it is in the Wolof concept of *yërmandé* which describes an emotion drawn from social relationships and expectations that demands material praxis and resolution. Cheikh’s financial contributions – e.g. the user fees, the prescriptions, and the rams – consequently perform emotional support (even if inadequate for Fama) and spiritual self-care. But without the somatic experience and expertise that Fama’s mother used to provide

her, Cheikh will always fall short, and so in that way, we also see how materialities and socialities can fall apart.



Chapter 5: A Father is Just a Man: Gender, Kinship, and the Entourage

Nitt nitt moy garabam.
(People are people's medicine.)
– Wolof proverb

One of the motivating questions of my research was to explore how men in Dakar prepare themselves for fatherhood. At first, this question was posed in a narrow sense to determine what men were doing *during pregnancy* in anticipation of being a father. The question arose because in 2012 and 2013, I had watched young single men engaging in various performances of masculinity, like catcalling, locker room talk, and sexual promiscuity (or claims, at least), and in 2015, many of these same men were married with young children. They considered themselves “serious” and “adult” in ways they had not when I knew them earlier. Later on, some of these men would come out to drink tea and chat with me and the still-single-guys, but they’d go home earlier than usual. “I have to go see my kid,” they might say. Or I’d join friends at a party or a nightclub and ask if a friend we hadn’t seen in a while might be there. “Oh, he has a kid now,” I’d hear. I had similar experiences in the US, where one might say, “Oh, he’s a ‘family man’ now.” So, I wondered: What had happened in the intervening years since I’d last seen these men? What forces and processes had occurred to shape them into the men who attenuate the time they spend with their friends (often childhood friends) and chasing women in order to take up the responsibilities of fatherhood and married life?

Pretty quickly, I came to understand that “preparing for fatherhood” was not a process bound within the nine months of pregnancy, but that it occurs over a lifetime of masculine socialization. As I’ve established in the Introduction, where “gender” is the practices and expectations associated with the body, it follows that “masculinities” are the practices and

expectations associated with the male body. Building on that, I add that “fatherhood” is the practices and expectations associated with the relationship between a masculine provider and the children they provide for. Not only is fatherhood is *engendered* through men’s experiences with fathers (their own and others), but so are spousal and caretaking commitments.

In the words of my adopted brother Diouf, “A father is just a man.” I take this to mean two things. First, it points to how men are socialized from a very young age to be caretakers and providers. Given that having children of one’s own is a foregone conclusion for most Senegalese men, it follows that this statement could be rephrased in the inverse: whether one has a child, men are fathers, either to other children or in a sort of dormancy. Second, it also takes a literal sense, in that fatherhood is a prerequisite of adulthood – *adult men* are fathers.

Like the previous chapter, which challenged the rhetoric of “men’s involvement” in global health, this chapter is an intervention into global health and development conceptions of nuclear families. In Dakar, men – as fathers and as husbands – are part of a much larger whole than a nuclear conception would have us believe and their roles are shaped by kinship, gender, and Islam in significant ways. If you were to look at husbands and wives, or fathers, mothers, and children, you’d miss a great deal of the relational context and it’d be easy to perceive men as harsh disciplinarians and women and children as their targets. This chapter is about what makes a man in Dakar and how kinship and social pressures inform relations between men and the people they care for. In other words, masculinities and families, in a way, co-construct each other. In a broad sense, what I aim to establish here is what is expected of men in relation to their families. In particular, I show that men’s roles are *vaguely specific* (and thus broadly interpreted) and also highly shaped by economic situations and Islamic practice – there is a template. Further, in Senegal, where “father” is not necessarily a biological kin term nor is “fatherhood” simply a

biological relationship, I add another layer by demonstrating ethnographically that the values of fatherhood are already well-established and present in the experience and perspectives of expectant fathers. This argument is both supported and troubled in the next chapter where I describe the complicated ways that men approach topics of pregnancy – that they claim to not know things about “women’s business,” but that they actually know and do more than they give themselves credit for, which produces an advantageous “absent presence” (M’charek et al 2014a, 2014b) of involvement. What I wish to focus on here is how men are socialized to become fathers and how their roles as providers fit into a broader kin network that involves a number of other actors. To best illustrate this network, I work not from the perspective of a father, but of two daughters – sisters Ndeye and Ida – because ultimately, they are the beneficiaries of the network of care which includes their father, Diouf, as well as other family members.

“Is it important for Senegalese men to become fathers?” I asked Diouf. “Generally, yes. A father is just a man,” he responded. “It is central [to men as a goal in life], but sometimes not. He must give his children an education first, but also, make sure they are fed.” But fathers are part of a much larger kinship network as well and they share their duties with others in ways not usually found within a nuclear two-body household. Diouf continued, “Luckily, we are in Africa: everyone has a father. Every brother of my father is my father. They made sure I had an education. Some of them hit, some of them speak [referring here to discipline].” Fathers must also remain emotionally and financially stable, so that they can provide an anchor point for their children. “A father gives lessons to his children. A ‘good’ father or a ‘bad’ father is still a father. One always wears that hat. He is like a library, a point of reference. That is the hat of the father” (*chapeau à papa*).

I frame this chapter by using what Emily Wentzell refers to as “composite masculinities” which, rather than referring to a singular habitus of masculinity, signals multiple habitus that “hang together” under the banner of a singular masculinity. Wentzell draws this from Annemarie Mol’s (2002) ontological rendering of bodily multiplicity in which the latter argues that nominally singular objects are “collections of things, events, and experiences” in practice, and are thus composite (Wentzell 2015:179). Wentzell thus defines “composite masculinities” as “contingent and fluid constellations of acts, attitudes, relationships, and physicalities that men weave into coherent masculine selfhoods through a variety of social and bodily practices” (2015:179). The concept is therefore congruent, in a gendered way, with the Senegalese historian Boubacar Barry’s assertion that the cosmopolitan Senegalese is “three-headed” (personal communication). What he means by this is that as a consequence of Islamic trade, Wolof ethnic hegemony, and French imperialism, the 21st century Senegalese thinks in “Arabic, Wolof, and French” – not just languages, but customs as well. These Arabic, Wolof, and French ways of being – “contingent and fluid constellations of acts, attitudes, relationships, and physicalities” – have profound influences on how the topics of this chapter – masculinity, fatherhood, care – get enacted in Dakar.

Take for instance that fatherhood metaphors in Sufi discourse, according to Joseph Hill, evoke connotations of “active begetting, inheritance, lineage, ultimate authority” as well as the face of the family (2014:285). The anthropologist Abdoulaye-Bara Diop, on the other hand, identifies Wolof fatherhood as transmitting the biology of “the bones, the nerves,” as well as the character of “courage” (1985:19). Men may take up both of these suites of characteristics without contradiction – they are complementary. This is a basic illustration of the concept of “composite masculinities”; where Carrigan et al. (1985) propose a diversity of masculinities with

in a population, and Connell and Messerschmidt (2005) suggest that individuals can strategically shift between masculinities, Wentzell's concept sheds light on how men might practice a plurality of masculinities at once. Wolof and Islamic obligations of fatherhood are dovetailed. Where Islam creates a canvas for responsabilization by imposing a parental obligation to care for one's children, the Wolof conception of fatherhood uses the canvas by ensuring that one's children are well-educated, well-mannered, and prepared to head families of their own. On the other hand, where Wolof conceptions of fatherhood demand that the father provide education, security, and discipline to one's children, Islamic practice provides the means to do so. These forms of fatherhood are so intertwined into composite masculinities that they cannot be analyzed in isolation – they must take each other into account as intersecting influences that compose a mosaic of subjectivities.

Islamic forms of discipline – that is, enforcing Quranic doctrine – dovetail with the Wolof's conceptions of childrearing (*Xale xamul Yàlla waaye xamna yar*. [“A child can't understand Allah but can understand the whip”; Perry 2009:50]). Quoting an informant, anthropologist Donna Perry writes, “A marabout once said there are two types of crying: the crying of a child and the crying of the parent. The first is much better than the second.” Quoting another, “A child is like a field. A few weeks after you seed it you see it sprouting real well. You might want to just leave it and let it blossom, but you better get on your knees and weed it real well! It's the same with your son” (2009:51). This is clearly reminiscent of the French phrase associated with childrearing: that one must *arracher les mauvaises herbes* (remove the weeds). Furthermore, she writes, “Wolof people compare children with a pliant piece of green wood that can and should be bent by force, given a shape that it will retain forevermore when it dries”

(Perry 2009:50). These metaphors of shaping, discipline, and order help us get a glimpse of what Wolof fatherhood might look like in the hinterlands of Senegal, but what they ultimately construct is a flat portrait of harsh, intergenerational authoritarianism.

Many of the men I knew were not the disciplinarians Perry and others would have us believe. Diouf, who I quote above, talked to me about his daughter, Ndeye. “I adore [her]. She is my friend. I am her friend. She is my daughter and I am her father. She adores me. I call her on the phone, I try to see her as much as I can. I think of her often, and I know she thinks of me,” he said. This tenderness is not a typical account of the way that Wolof or Sufi fathers think of their children, as far as scholarly literature is concerned, but this kindness toward children (and wives) was fairly common during my time in Dakar.

Wolof kinship, as observed of kinship elsewhere in sub-Saharan Africa, is a complicated web of relations, not always clean or consistent, and impossible to illustrate in a linear way. It’s not compatible with global health conceptions of family and care. Abdoulaye-Bara Diop’s 1985 classic “*La famille wolof*” (English: The Wolof Family) expresses the same frustration that I found in trying to investigate and represent kinship ideologies among Wolof speakers. Depending on who you talk to and when, he says, Wolof kinship can be matrilineal, patrilineal, bilateral, double unilineal, or unilineal. This, Diop explains, is due to the malleability of the system in the face of various historical changes and interactions, such as Wolof monarchies, the spread of Islam, French colonialism, and economic development. Thirty-five years after the publication of his foundational text, I would add: climate change, transnational migration, neoliberal structural adjustments, the expansion of reproductive health technologies, and global media (including the internet) have all had major effects on kinship structures and gender roles in

Senegal and the world over. I don't wish to explicate the finer technical details of a kinship system anyway, rather set the stage for explaining the important kin roles with respect to prenatal health and care. Nor is this chapter about *Wolof* kinship as an exercise that furthers the tyranny of *wolofization* in Senegal, though this is a fair critique given that roughly 40% of the Senegalese population are Wolof, though over 80% of the population speaks at least some Wolof. It is certainly true that not everyone in my research adheres to a "Wolof kinship system," but I would add that even the Wolof (who made up the vast majority of my research participants) don't always adhere to the same kinship roles anyway. (And further, it's debatable that any one system even exists.)

When I met Ndeye, she was 7 years old with big, inquisitive eyes and beautiful twisted hair. Her father, Diouf, is a big guy and a construction worker who towers over everyone, so there is an additional adorable quality that little Ndeye has his eyes and smile – she is a "mini Diouf," some would say. (Those qualities are present in Ida now as well, who was born during my dissertation research.) When Ndeye was younger, she would sit on his lap and play games with him, but today she is beginning to think he is decidedly uncool. Today, Ida is 2 years old and insists on calling her parents by their names (which they find hilarious and frustrating) and often asks "Ana Dick?" (Where is Dick?) while grabbing her own nose as if to specify that she is speaking of the Dick with the septum piercing.

Ndeye and Ida have complicated relationships with their family, but these are characteristic relationships of a multigenerational family spread across continents and colonialisms. Her parents, Diouf and Fatou, do not live together, though they are married, and she lives with her mother. They do not live together, because there were significant social forces that set them back, mainly the caste system. Much of West Africa has a caste system that divides

society into social classes based on their trade skills and social roles. Ethnographies of West Africa up through the 1980s discuss caste as a prime animator of social relationships and movements, but caste rarely makes any meaningful appearance anymore.

In 2013, during my first solo trip to Dakar, my advisor, Barbara Hoffman – who had written an ethnographic monograph, “Griots at War” (2000) about griots (a caste class) in Mali – instructed me to look out for caste relations. Of the dozen young men I interviewed that summer, no one knew their own caste grouping when I asked. Diouf, my brother, explained, “No one knows their own caste because caste doesn’t matter. That’s a thing for old people.” When I reported this to my advisor, she sent me a news article about how the octogenarian former president Abdoulaye Wade had called the newly-elected president Macky Sall a descendant of slaves (another caste class), as if to say, “See? Caste is relevant!” When I showed this to Diouf, he nodded, “Like I said, caste is a thing for old people.” In seven years of visiting Dakar, I have never witnessed caste come up in conversation or determine how people related to one another – save for one single instructive example.

This vignette is instructive of the rapid generational change around kinship and more specifically fatherhood in Senegal. Some of these changes are occasioned by influences that I have already hinted at, including the rapid monetization of the economy, transnational migration, and urbanization. And it’s not that caste is a “thing for old people,” in that one’s attitude changes later in life, but that it’s a dying custom. “Anyone can marry anyone,” Diouf told me. “Will you let Ndeye marry someone who is *jamm*?” (slave), I challenged. “Of course,” he said. To complicate matters, however, this is not just a generational phenomenon but a regional difference as well. People in my study suggested that caste is still somewhat important in rural Senegal because anonymity is harder to achieve there, whereas in Dakar, it’s more likely that marrying

families may not have established generations of *koleré* (mutual relationships, loyalty between families) found in the hinterlands. At the same time, as rural-to-urban migration increases at an exponential pace, rural families are building relationships across great distances with Dakar and other cities as a meeting point.

By 2015, I'd known Diouf for two years. I watched him struggle to raise money and resources for Ndeye and her mother Fatou, to whom he was not married at the time. Fatou is a professionally trained beautician and her skills are highly in demand come the holidays. Diouf, ever the entrepreneur, assembled investors and contractors to build a brick-and-mortar location for her salon. At the same time, I watched as he anxiously worked to round up the cash for his daughter's school fees and purchase school uniforms and supplies. We were often going out to buy take-out food to drop off to his daughter and her mother; they were often on his mind.

Back in 2013, he told me that he was saving money to marry Fatou. In 2015 I recalled his intention and asked how the progress was going. It had turned out those plans had been foiled by his father. I was confused. "It's about the caste system," he said. "My father won't allow us to marry because we're from different castes." "Wait a second," I objected. "You told me that caste wasn't important, that caste is for old people, and that no one in our generation cares about those things!" He laughed and then sighed, "Yeah, that's still true, but here's the thing: In Africa, we do what our fathers tell us. If caste matters to him, then that still affects me." His family chose another woman for him to marry and he did. They lasted a few months before he ultimately divorced her and went back to saving money to marry his daughter's mother. Fatou and Diouf ultimately married in 2017, which put his closest kin relations in a bind.

Diouf's parents are long divorced. His mother is a Christian, whereas he and his father's family are Muslim. Diouf took his father's youthful marriage to his Christian mother as

permission to marry Fatou, since non-Muslim women are supposed to convert before marriage and she never did. Diouf's mother's side of the family does not get hung up on matters of caste and religion. They adore Fatou and their grandchildren and they are glad to have them in their lives. Diouf and his father remain tense. A couple of his father's brothers and their wives won't even talk to him anymore. His father's brother with whom he still maintains a close relationship and the brother's wife have chosen not to take sides, but instead mediate the conflicts between him and his father, as they have done since Diouf was a teenager, as does Diouf's paternal grandmother.

Ndeye and Ida's relationship to the family mirrors her father's relationships – they do not see those family members, almost ever, as the girls are the products of this socially illicit union, but also because Diouf believes that if those family members aren't willing to accept his wife and children in the family, they aren't good people that he wants his children to be around anyway. His paternal grandmother and those mediating family members, however, don't hold anything against the girls, and they all maintain good relationships.

Today, Ndeye and Ida live with their mother, Fatou, as they always have. They live with Fatou's parents and siblings. The house is only a couple blocks from Diouf's family home in Médina, so it was relatively easy for Diouf to see them daily. In 2017, after their marriage (and before the birth of Ida), Diouf, Fatou, and Ndeye moved to a small two room apartment in Médina for a year, but ultimately had to leave because the landlord regularly raised their rent, cut off their utilities, and harassed them. That's when Diouf had the idea to build a home in the Parcelles Assainies neighborhood on the northern coast of the peninsula. The plan was to build the house and move his family there. It was not close to Médina, and this upset Ndeye and Fatou – Ndeye, because she wouldn't get to see her friends and family as often; Fatou, because her

business was in Médina. Diouf promised Ndeye that she could continue to go to school in Médina, and that she and her mother could just commute there daily – an additional expense that he was confident he could manage. When the house was ready to move into, his wife and children spent their weekends there, but they were never enthusiastic about actually moving in. It didn't make sense given that Fatou lived with family above her salon, and Diouf has always had trouble keeping stable employment and consistent contracts. So far, Ndeye has been spared. The hardship is on Diouf who more often spends time in his wife's family home in Médina than his new home in Parcelles.

These kinds of ruptures in what is and what should be open a window for us to see how kinship works in everyday practice in Dakar. It is arguable that every anthropologist in Senegal knows the work of Abdoulaye-Bara Diop and the incredible detail of his descriptive analysis, but his work does not tell us how the rules play out or break down.

As Diop writes, there is a gendered division of labor in the household: women tend to work in the home, while men work outside the home. The first time I was in Dakar, during a discussion about gender with some young men over tea and cigarettes, one guy told me, “You know, in America, people are always saying that it should be ‘50/50’, but you know, we have 50/50 here too!” I remember being amused that in the midst of this entirely French conversation, “50/50” was pronounced, “fifty-fifty.” “How is that?” I asked. “Women do all of the work in the home and men do all of the work outside of the home. That way, they both do half of all of the work that is required to maintain a household.”

Households in Dakar are, by and large, multigenerational and the physical structures – whether single family houses or apartment buildings – are organized around a central courtyard.

The courtyard can be a site of cooking and sharing meals, washing and hanging laundry, and children's play. It is, in essence, a space made feminine by virtue of the activities done there, which are socially feminine in Dakar. I mean this in the sense that women typically do these activities, but also that men are socially barred from doing them. In large family homes, it's common for men and women to eat separately. Young children always eat with the women. Even in the home that Diouf and I shared before his wife and children began visiting regularly, we were still compelled to hire a woman who lived across the road to do these things.

Typically, when a couple marries, the new wife moves into the new husband's household and joins the domestic labor force. Tasks are re-apportioned between junior women of the household, but they're flexible depending on the circumstances. For instance, when a woman in the household becomes pregnant, she spends most or all of the pregnancy in the home under the watchful eye of her *goro* (mother-in-law), *njèkke* (eldest sister-in-law), co-wives (if applicable), and other women in the household. Over the course of the pregnancy, she will slowly attenuate the amount of domestic labor she does and these other women will pick up the labor for her, or the family will hire a housekeeper to help or take over all of her domestic labor. (Often, the housekeeper is a neighbor who needs the work, but sometimes she [almost always "she"] is a relative from the interior of the country.)

More often in rural communities in Senegal, but not uncommonly in Dakar, women will go to live with their own mothers in the final months of the pregnancy and first three to six months of the child's life. In Dakar, where families joined by marriage often live fairly close to each other, moving from one house to another is not totally necessary. Even under these conditions, women may nonetheless find it necessary if, for instance, they have a poor relationship with their in-laws or if she and her husband live together alone.

In the case of Fatou and Diouf, who were expecting the birth of Ida in late 2017 (though Ida was not born until January 2018), there was no better place for Fatou to go than to her mother's household (where she already lived). The house in Parcelles would not be livable until May of 2018. Even then, Diouf told me, "Ida can't leave the house until she's 6 to 8 months, otherwise she could get sick." It was never clear to me whether he was commenting on sickness from *malchance* (bad luck, evil eyes, etc.) or pollution, as Dakar has terrible air quality.

Médina is dusty, the pavement is greasy, there is trash in the gutter, walls are tagged with political graffiti. It's beautiful. The colonial suburb is set up like a grid, and 100 or so feet off a main road is Fatou's salon where she fashions chic new hairstyles, wigs, weaves, and extensions. She works with a makeup artist, nail artist, and other beauticians in the crowded space, but at least she's always busy. The salon is clean, free of dust and debris, even though the doors remain open to ventilate the fumes of the hair product. Diouf worked for a whole summer completely remodeling the space just for her, so the inside sports a relatively new paintjob and massive, spotless mirrors, while the outside boasts hand-painted murals of the Sufi saints Cheikh Amadou Bamba Mbacké and El Hadji Malick Sy. Not only is this a space that stands out in the neighborhood for how clean and new everything is, it serves as a landmark for the well in the middle of the sidewalk directly in front of the salon doors where people come to get water and congregate to exchange greetings, job tips, and gossip.

Fatou and her daughters live above the salon with her family. To get there, you have to bypass the salon and squeeze into a relatively narrow alleyway that leads into a central courtyard shared by a couple different buildings. Laundry hangs, rice cooks, children run. There, a steep set of misshapen stairs leads up the back into the living room. (The handrail doesn't begin until

halfway up the staircase. I always feel like I'm going to fall up or down these stairs.) Another flight of stairs continues up to the roof where there is a kitchen, and a large open space for laundry or dining, depending on the time of the day.

Until Ida was about 8 months old, if I wanted to see the girls, I had to go to Fatou's mother's house. The living room was small, but packed full of three couches and a small television. There was a large rug on the tiled floor where people would sit and eat, and a pile of shoes in hallway outside the door. There was one small window and one large set of doors that let out onto the balcony overlooking the well, but the curtains were always drawn. This space was always an escape from the elements.

The first time I met Ida outside the hospital was just before her *ngente*, before she even had a name. I sat on one of those couches between Fatou's sister and cousin. She and her mother sat on another couch. Other older women sat around the room. Fatou's father and teenage brother were there too. Children sat on the floor. Diouf stood near the door looking upon the network of people who had supported him and his wife through the pregnancy. One at a time, Ida was passed around from person to person, tightly swaddled in a white cloth, laying her on her back in a closed lap, and rocking her side to side from the hips. When it was my turn, I handled her awkwardly, as everyone expected me to do. There were giggles, but eventually I got her in motion. Ndeye took her to the floor and laid her in her lap with her legs stretched out and rolled them side to side. After a few moments with Ndeye, Diouf reach down to pick Ida up and took her to his chest. He was hypnotized by her. He was a pro at holding her, even though she was the first baby he'd ever held only a few days before this.

"I don't really hold babies. What if I break her?" he asked me over text, two days after Ida was born.

“Brother, babies are resilient little creatures.” I said. “Did you know their skull has to change shape just to come through the mother’s pelvis? Just try it. You’re not going to break her.”

“Okay, but what if she poops or vomits?” he retorted.

“Then she poops or vomits. She’s a baby and you’re her father,” I said. “You can take it. You’re resilient too.”

“Okay. I will try then,” he resigned. And then I didn’t hear from him.

Later, when I saw him at home, he came through the door. “I did it!”

“So, how was it?” I asked

“It’s [very long pause] everything,” he smiled. “It’s life.”

This time – my first time meeting her – was days later. “I just can’t put her down!” Diouf told me in front of his family. She fussed a little throughout her introductions to the family, but ultimately slept through it all. Over the coming months, Diouf would get a reputation for being the only person who could stop Ida from crying when he’d walk into the room.

As Diouf said above, an individual can have many “fathers” (*baay* in Wolof, *pa* in French). “Everyone has a father.” All of a father’s brothers are called “father.” They have all the same rights and responsibilities as the biological father, should they choose to exercise them, and they demand the same respect and piety as the father. Mothers (*yaay*) are primary caregivers throughout childhood, though fathers take an increasingly active role with boys as they reach puberty and beyond. As with the father and his brothers, mother’s sisters can be considered analogous to the mother, but they are ultimately overshadowed by the *bajen*, or the eldest paternal aunt. While *bajen* designates a particular kind of amital relationship to a child, the same

woman is called *njেকে* by her sister-in-law, the mother of the child⁸. *Njেকে* literally means “female husband,” as demonstrated by the shared etymology with the word for husband, *jেকে*.

The *njেকে/bajen* is a significant person in the reproduction of family and kinship. As the *njেকে*, her job is to care for, advise, and sometimes discipline her brothers’ wives. As it relates to prenatal care, her job is to act as the stand-in for her brother in matters of decision-making and clinical consultations while he is out “finding the money.” The role of the *njেকে* is also fraught with infamy. “The *njেকে* is the most dangerous [to a pregnant woman],” the midwife told me in our first meeting. “She holds power over her brother, the expectant father.” How is that, I asked? The midwife explained that when a woman becomes pregnant, she will immediately benefit from the advice and affection from the *goro* [her mother-in-law], and this attention can make the *njেকে* jealous. Because the *njেকে* acts as the female husband, she can use her power over her brother to dictate certain decisions. Even worse, because she is still her mother’s eldest daughter (or second, in the case of a junior *njেকে*), she can turn the *goro* against the pregnant woman. Where men have limited resources to distribute to his immediate family members, the *njেকে* and the *goro* may then demand more, leaving his pregnant wife with little. And while I’ve heard this family dynamic described again and again, I’d never seen it in action. Nonetheless, it was a cautionary concept that people held. Given her power over her brother and the special bond created with her nieces and nephews, it’s no wonder, then, why she, the *bajen* to the child, might overpower her sister-in-law as an authority figure in the family⁹.

⁸ It should be noted that there could be more than one *njেকে* - the two eldest sisters of the father - but I’ve never seen more than two.

⁹ Furthermore, it makes sense why the program *Bajenu Gox* - neighborhood *bajen* discussed in Chapter 6 - would take the name that it does if the goal is to get clients to pay attention and take advice about reproductive health issues.

Seven days after childbirth at the *ngente* - the name ceremony or baptism - it is the *njèkke* who gives the name to the newborn. Typically, though not always, she keeps this to herself until asked by the imam during the ceremony to give the name. It's not uncommon for the *njèkke* to give her own name, in the case that the newborn is a girl, making them *turando* - twins by name - and signifying an extra special bond on top of being the child's *bajen*. In any case, naming is taken very seriously, and children are always named in honor of someone else.

Ndeye, Diouf's eldest child, was not named after her *bajen*, rather she was named in honor of Diouf's *bajen*, with whom he is very close. "She carried me on her back when I was a baby. That's how close we are," Diouf told me, referring to a practice that tends to be reserved for mothers¹⁰. In fact, they are so close, he calls her "mother." Ndeye's real name is the same as Diouf's *bajen* (and thus they are *turando*), but just as he would never call his *bajen* by her name, so too does he refuse to call his daughter by her name, opting instead to call her *ndeye* – a Wolof term for "mother"¹¹.

Diouf's other daughter, Ida, on the other hand, is named for her *bajen*, but it too is more complicated than it seems. As Diouf's father relocated his family to the United States and left him behind when he was 16, his eldest sister does not live in Dakar and rarely visits, though they talk often. But because Diouf's paternal cousins are considered siblings (as they are the children of his other fathers), his eldest sister (cousin) in Dakar takes up the role of *njèkke* to his wife and

¹⁰ Photographer Mara Moreiras' project is particularly unsavory in light of these cultural norms.

<https://www.bbc.com/news/world-africa-47922717>

¹¹ This inheritance of names is similar to what Lisa Stevenson calls a "skewing of kinship terms" in her discussion of Inuktitut atiq (2014:105). There, she writes, Inuit pass the names of their dead relatives to their children, refer to them by their kin terms, and look for physical and behavioral signs of similarities between children and their namesakes. "One day I heard a friend calming her baby by saying, 'Anaanakulu, anaanakulu' (My dear mother, my dear mother)," Stevenson writes (105). While the "skewing" is not uncommon in Dakar, I have not witnessed an indication that, for example, Diouf might also perform the same kind of filial piety for his daughter as he does his *bajen*.

bajen to his children. Ida, however, was named by this sister/cousin in honor of Diouf's eldest sister who lives in the United States.

Islam plays an important role in the crafting of masculinities and fatherhood in Dakar by giving men the tools to perform to their expectations. I was frequently told that fatherhood in Senegal means keeping one's children "on the right path" (*le droit chemin*) which entails, as Diop wrote, ensuring a good education and keeping discipline, and at the same time, demanding sovereignty as the *borom keur* (head-of-household). Diop's emphasis on notions of sovereignty and providing education are points at which "Wolof fatherhood," if that can be bracketed, complements Sufi practice. "The good child" is one who obeys their father without question because that is what the Prophet Muhammad has written. Additionally, Sufi leaders are often referred to metaphorically as "father" or "baay" (Hill 2014; Malamud 1996). As Hill writes, these metaphors of fatherhood signal that followers are surrendering absolute spiritual authority to their cheikhs. As it concerns education, Senegalese fathers are only entrusted with providing a quality education (whatever that might mean to them), not any particular kind of education – *carte blanche* is given to the man who may want to send his children into a *daara* (Quranic school), though this was never the case for any of my research participants, all of which attended French-speaking public schools and intended to send their children there as well.

Combining these two notions, it becomes apparent that at this Sufi-Wolof nexus, fathers have a capacity to be spiritual leaders for their families until, perhaps, one's children become *talibé* (disciple) themselves. "The father must teach the Qur'an," said one of my interlocutors. In *daaras*, where children are fostered by marabouts, Perry (2004) writes that fathers are insistent that the children remain with the marabout for the full term of their education, despite poor living

conditions. Quoting Cruise O'Brien, she writes, "there is the advantage of establishing a connection between the family and the powerful [Muslim] brotherhood, for a father who offers his child to [a marabout] establishes a claim to the latter's gratitude" (2004[1971]). In this way, it is conceivable that the father is benefiting his child in two ways: by ensuring that he gets a moral and religious education in a Quranic school and by securing social capital through the establishment of an important connection with a brotherhood.

These are roles of *borom keur* (Wolof: head of household) and *kilifa* (Wolofized Arabic: spiritual head of the family). Specifically, with respect to the family, those roles are to maintain the health and safety of the family, manage the household finances, and educate the children. "Educate," here, can mean anything from physically or verbally disciplining children to ensuring they receive an education at a Franco-Senegalese school or *daara* (Quranic school). Dakarois fatherhood and faith in Allah go hand-in-hand, as is evident in the Wolof proverb, *Xale xamul Yallah waaye xamna yar* ("A child does not understand God, but they do understand the whip"). It is important to note, as a window into how intertwined piety, discipline, and education can be, that *yar* signifies both "whip" and "training."

This is what I mean when I say that the roles of fatherhood are *vaguely specific* – men have a loose framework of what is expected of them, but their performance of those roles is largely determined by how they were raised (positively or negatively) and how social pressures might shape the interpretation of those characteristics. A good example of how this plays out is in the changing attitudes toward polygyny and birth planning.

The Senegalese *Code de la famille* (Family Code) is a highly contentious set of rights and regulations granted by the state to spouses and children. The Code has been rewritten and revised several times since formal independence in 1960, always with great controversy, mostly between

conservative Muslims who believe the state has no business in family affairs and more progressive factions who think the state does not go far enough. For instance, under the Code, divorcées are entitled to child custody, child support, and alimony, whereas under Islamic law, those benefits are negotiable, but unlikely – especially in cases of custody, because children are far more likely to go with the father. To avoid the reach of parts of the Code that deal with marital rights, most of the Senegalese people I have known have opted for a religious marriage while foregoing a civil marriage. (To clarify: All of them have religious marriages, some get a civil marriage too.) Without a civil marriage, the union is not recognized by the state. And since there is little benefit to having a civil marriage (tax breaks are negligible to non-existent, for example), there is little incentive for people to have their marriage recognized by the state, when marriage is largely seen as a matter for families and even communities, at the highest level.

As Senegal is a largely Muslim country (most estimates agree that Muslims make up more than 90% of the population), the Code allows all Senegalese men (Muslim or not) to take up to four wives, in keeping with Islamic custom. Couples who do get civil marriages have to indicate on their marriage licenses whether they intend to remain monogamous or become polygynous. According to Ndiaye (113), the ideal head-of-household (*borom kër*) and model of success is he who marries at least three women and maximizes his reproduction. Polygamy is a normal part of life in Senegal, but little has been written on the rate of polygamy. Indeed, the national office of statistics (Agence National de la Statistique et de la Demographie, or ANSD) does not record such data. While I have met and known polygynous men in Dakar, they're all either older than 50 years of age or they're migrants from the interior of the country. In other words, I have reason to believe that polygyny is on a steep decline among young and middle-aged urban men with whom I interacted – at least formally. It's important to distinguish here

between *de jure* and *de facto* polygyny. Men regularly call themselves polygynists, “Je suis polygame!” (“I am polygamous!”). And some, in the cases that they get civil marriages, register with the state as polygamists, even if they have no intention of taking a second wife. In Chiekh and Fama’s case (the couple from the previous case), they had a civil marriage in addition to the religious marriage because it was what Fama wanted. When filling out the marriage certificate, Chiekh registered himself as polygamous, even though he swore to me that he would never, ever take a second wife. His reasoning, he says, is so that he can hold it over Fama’s head if he needs to, because Fama isn’t convinced that he wouldn’t. If she ever upsets him so badly, Chiekh can threaten her with taking another wife. In practice though, she calls his bluff. “I wish you would,” she told him. “Then someone else could do the cooking and take care of the kids for once.” It’s common for men to do this, Cheikh tells me. His cousin had recently married and registered as monogamous. “What are you doing?! Are you crazy, or what?!” he remembers asking his cousin. “Now he has no way out if things get bad.” We see here how some men instrumentalize the law, which is regarded as having too much reach into family life, in order to wield power over family life itself through the strategy of developing an ostensible back-up plan.

In practice, however, men are not interested in formally marrying multiple women, only having extra-marital affairs with them (Parikh 2015:96). First and foremost, formal marriage is expensive, not only financially but emotionally. Indeed, the Qur’an (Sura 4 Ayah 3) advises that men may take up to four wives so long as they can be supported financially and emotionally, which for most men in Médina are more wives than they can manage with limited resources.

Digging deeper, however, it’s common to hear younger men talk about their own experiences as children of polygamous fathers, and always in a negative light¹². They often say

¹² Similarly, Parikh has described young Basoga as highly critical of their parents’ marriages (2015:93).

that they didn't have a close relationship with their fathers, usually because his attention was spread so thin between work, multiple wives, and very many children. One man remarked, "If I ever got attention from my father, it was because I was in trouble." Another man told me that he had poor relationships with his mother's co-wives. Therefore, not only is the decline in *de jure* polygyny an indicator of men's lack of resources to support more than one marriage, it is a sign of the desire that these disaffected men have to play more active and intimate roles in their own children's lives than their fathers did with them. As a result of wanting to foster better relationships with their children, the men with whom I worked expressed disinterest in fathering many children. Many of them, as a product of polygyny, were one of as many as 12 to 14 children. On average, men reported wanting four children max, so that they could have a relatively small, tight-knit, and manageable nuclear family that still enjoyed the benefits of maintaining extended and communal kinship.

We can't talk about polygyny and the discussion of how many children one wants to have without talking about birth spacing as well. In Dakar, as in much of Senegal, there has been a concerted effort on the part of the state (through *Bajenu Gox*) and *Cadre des Religieux pour la Santé et le Développement* (Religious Group for Health and Development, or CRSD) to talk to men about birth spacing. The organization is an NGO concerned with development of health and development initiatives in religiously sensitive ways. One of their primary focuses is to work with imams on ways to talk to their congregations about Quranic justifications for birth spacing. (I explore *Bajenu Gox* and the CRSD in more detail in the next chapter about how the state mobilizes rhetoric in the production of gender and subjecthood.) The religious arguments for birth spacing, in particular, have filtered down to many of the men I spoke with. "You have to use contraceptives and condoms. And you shouldn't be having children until you're sure they

can be supported,” Diouf once told me when I asked about his thoughts on the matter.

“Otherwise, women and children end up living in the streets. You think God wants women and children living in the streets? No.” Homeless women and children are seen as reflections of morally bankrupt fathers and husbands. As one interlocutor told me, “It is the father who takes care of the family, who looks out for them and protects them... If you see a young girl who is sick [on the street], you do you think is to blame? The father.”

In this chapter, I have demonstrated the broader context of what masculinities and fatherhoods look like in a multigenerational family environment. I have shown how generational change, economic hardships, and Islam all shape fatherhood in different ways. Combining the core arguments of the last chapter – that expectant fathers are expected to provide financial and emotional support to their pregnant partners – with the familial context of this chapter, we get a better picture of how men play ultimately limited yet profound roles as providers for their wives and children, and how their support is complemented by other kinds of support from other family members. Furthermore, the descriptions of different kin roles in this chapter – particularly of the *bajen* – will be important in the following chapter in which I describe how the state has attempted to translate the culturally important role into social impact by way of the *Bajenu Gox* program.



Chapter 6: Prenatal Rhetoric: How the Senegalese State Enlists Expectant Fathers to Aid in the Discipline of Pregnant Subjects

Saabu du foot boppam.
(Soap does not do laundry alone.)
– Wolof proverb

In the previous chapter, I explored the entourage of the pregnant woman in Dakar. I discussed how this tightly-knit network of kith and kin can support a pregnancy to the extent that men play a proportionally smaller – though arguably the most important – role. In this chapter, I move outward from the pregnant woman into other resources that make up a part of the network of care – a state-mandated pregnancy manual (the *carnet*) and a women’s health advocacy program (*Bajenu Gox*) primarily, but I also turn to the birth-spacing campaign of a local NGO called *Cadre des Religieux pour la Santé et le Développement* (Religious Group for Health and Development or CRSD). The former two programs (the *carnet* and *Bajenu Gox*) demonstrate a mobilization of “absent presence” (M’charek et al 2014a, 2014b) in that the very omission of men from educational materials enlists them as active participants in prenatal care. The latter program (CRSD’s birth-spacing initiative), on the other hand, which addresses men directly, demonstrates what it might look like if the state followed a similar strategy. Across all three programs, I use rhetorical analysis drawn from Marika Seigel’s 2014 work on American pregnancy manuals in which she outlines how texts characterize “good healthy subjects” (the characterizations are called “pieties”) and how they compel readers to adhere to those characterizations in a process called “articulation.” I move beyond her analysis to suggest that when men see that they are not present in the texts, they are reaffirmed that pregnancy is not their business in a process I call “anti-articulation.”

I conclude with a brief prospectus on emerging pregnancy texts in Dakar and how they may or may not involve men in new and different ways. These texts include a newly published, private self-help guide and the popular use of YouTube videos instead or in addition to the *carnet* or *Bajenu Gox*.

My interest in gendered spaces is not simply physical spaces or conversational spaces, but space as a form of knowledges into which men typically did not enter. The phrase *affaire-u jiggeen*, or “women’s business,” came up again and again in my conversations about pregnancy (and also in literature [Buggenhagen 2011]). I wondered how firm (or, porous) the boundary was between what men knew about pregnancy, what they didn’t know and what they weren’t supposed to know, and I wondered how men learned what they did know. I also wondered “who” reinforced or subverted those boundaries, but quickly came to realize that “who” was too active and direct – too rational – a framing; rather, I was interested in the more passive and historically contextual: *How* are the boundaries reinforced?

Boundary maintenance, here, should not be read as a defense of privileged or mystical knowledge. Matters related to pregnancy (and other types of “women’s business”) are not strictly guarded family secrets passed from mother to daughter to which men can never be privy. It is a private matter that I would instead relate to most U.S. men’s (dis)interest in menstruation: some men may be aware of their partners’ menstrual cramps and may even feel sympathetic enough to grab some painkillers and warm up a heating pad for her, but they are likely not interested in knowing any of the more intimate details of their partner’s period, or even a general understanding of how menstruation works. Furthermore, if a man does concern himself with these things, he may be thought to be rather strange or progressive, depending on who is interpellating him. The same goes for the men in Dakar with whom I interacted: they may be

aware of the discomfort, the swelling, the morning sickness, and the cravings associated with pregnancy, and they may even be sympathetic enough to attempt to relieve those things, but for men to be concerned with the more intimate details of a pregnancy would likely have him labeled “*goor-jiggeen*” (a modern slur for homosexual, literally “man-woman”) or “*tubab*” (foreigner; American or European in this context).

The Carnet (Handbook)

In one of my weekly meetings with Madame Ndour, the head midwife at *Hôpital du sud*, she showed me a patient’s *carnet*. As she opened it up, she flipped through the pages to show me how they were filled with advice and information about what pregnant women could expect (such as morning sickness or indigestion), how and what to eat or avoid eating, what kinds of household chores they could continue to do and what they should abstain from doing, how to recognize health emergencies and more. The pages were illustrated with small, hard-to-see images of women in traditional clothing preparing meals and riding in taxis to health clinics. These, Madame Ndour explained, were for illiterate women, but she also pointed out that more often than not, there is someone in the household who could read the *carnet* for her, which in turn promoted or reinforced a social support network. The assumption, and hope, that she and other midwives drew was that that person would be the expectant father himself, that way while he learned about pregnancy, he could sensitize himself to how her life would change and how his expectations of her should change. Interspersed between many of these pages were graphs and charts and empty tables waiting to be filled in, but these were not for the women – they were spaces for medical information to be recorded by midwives and doctors. In general, I am told, state hospitals and clinics in Senegal do not keep medical records for pregnant women – they

have neither the space for hard documents or the information technology infrastructure to keep digital files, therefore women must keep these books with them and take them to their appointments throughout the pregnancy. However, I did note in every maternity ward where I had the privilege to meet with a head midwife that they had a *Registre Consultation Pre-Natale*. This large book served mostly to document the addresses and phone numbers of the patients, but there was space to record minimal medical information that overlapped somewhat with the *carnet*.

Near the end of one of my weekly meetings with Madame Ndour, I asked her what I needed to do to get my own *carnet*. She told me I'd have to ask the Chief Physician of the hospital, Dr. Maguette. I sent him a brief email asking if I could buy one. I didn't want to put the hospital out by taking this resource for free but he assured me I could just have one. I would need to tell Madame Ndour that he was giving me permission. The next week, when I returned to Madame Ndour's office, she informed me that she does not keep them but that I'd have to go to the front desk of the maternity ward to receive one and that requires a prescription. She pulled her prescription pad and smiled as she wrote my name and the words "1 *carnet*," telling me to take it to the receptionist. "I don't think I've ever written a prescription for a man in my career," she laughed. I went to the receptionist with my assistant, Fatimata, handed the receptionist my prescription, and she handed the *carnet* to my assistant, a woman. "No, no! It's for him!" Fatimata laughed. "And who is the father, Dick?" she teased. "It's you, Fatimata. You're gonna help me birth my dissertation."

The cover of the *carnet*, officially called "*Carnet de santé de la mere et de l'enfant*" (Health Notebook of the Mother and Child), shows an illustration of a nuclear family: a man and woman, a young girl, and a baby. The man wears a button-down shirt and black slacks and he

has his arm around the young girl who is pointing to the baby. The girl is wearing a red and white dress, her hair is braided tightly into a small bun on the back of her head. The woman is wearing a wax cloth peplum top and pagne with her hair partially covered. She is holding the baby, wrapped in a white cloth, in her arms. The parents are smiling. This is clearly an imagination of and by the state who authored this educational material: the casual way the woman holds the baby is distressing; the people are smiling; the family is small – none of which I have seen in any of my own photographs of Dakarois families. The juxtaposition of the man's European dress against her more traditional form is telling of their social and kin roles – that he ventures out daily into the workforce while she may very well do the same, but with specific gendered expectations about how she does so. (Women who dress similarly to her depiction are often housekeepers or market vendors, while those who dress *à l'euro péen* tend to be business owners or have middle-class, salaried jobs.)



Figure 6.1. The cover of the Carnet.

Three logos stick out at the top of the cover: The Senegalese flag and the words “Republique du Sénégal: Un peuple, Un but, Une foi” (One people, one goal, one faith); the logo for the *Direction de la Santé de la Réproduction et de la Survie de l’Enfant* (formerly the DSRSE, now [and henceforth] the DSME, or “*Direction de la santé de la mere et de l’enfant*”); and the logo of the *Ministère de la santé et de l’action sociale* (Ministry of Health and Social Action; MSAS).

The *carnet* is not just a pregnancy guide, as I had initially thought, but a manual for raising “healthy” children as well, as defined by the state and global health agencies. There are chapters on breastfeeding, child nutrition, vaccinations, and more. The back of the book is covered, like a NASCAR stock car, in the logos of international health organizations who sponsored and influenced its creation: Helen Keller International, World Health Organization (WHO), United States Agency for International Development (USAID), the Canadian government, the European Union, United Nations Children’s Fund (UNICEF), Japan International Cooperation Agency (JICA), IntraHealth, the Senegalese “*Cellule de Lutte contre la Malnutrition*,” AMREF (formerly the African Medical and Research Foundation), United Nations Population Fund (UNFPA), FHI360 (formerly Family Health International), the Micronutrient Initiative, UKAID (the UK Department of International Development), Korea International Cooperation Agency (KOICA), World Friend, *Junta de Andalucia*, and the *Agence Francaise de Développement*. There is text above the logos that says “This health book should be preciously conserved by the parents or the person in charge of the child or adolescent. It should be maintained because it concerns the health of your child for the duration of their entire life. If you find this book, please return it to its owner or to the nearest health structure.”



Figure 6.2. The back of the Carnet.

The *carnet* represents the state's and public health ideal for maternal and child health, the information contained within it being decided upon, packaged and distributed authorities of health knowledge. Hence, it is striking that a book aimed at promoting proper gender roles contains little, if anything, on men or their involvement in pregnancy or child rearing. There are two places where men make merely implied appearances before the book turns from labor and delivery to childrearing. In the first, there is a breakout box about nutrition and timing. There are a few bullet-points and an illustration. One bullet-point reads "Introduce at least two supplementary meals between principal meals." The illustration shows the cycle of meals in a day: three meals in which a pregnant woman eats with her husband, and one in between each of

those meals in which the woman is shown eating alone. In this formulation, women work at home while men leave the house for work. It is common for men to come home in the middle of the day to eat lunch with their families, which the wives have been preparing since the late morning, among other household chores. Eating together is an important social aspect of Senegalese family and community, therefore married couples usually eat breakfast, lunch, and dinner together. (Seeing someone eat alone can actually be cause for *yërmandé* [pity].) It is expected that pregnant women will want to eat more frequently than usual, and in this passage, women are encouraged – if only in illustration – to not wait for their husbands to get home for lunch or the afternoon snack, but to eat when they feel that craving. What is interesting here is the assumption that the husband would be home for dinner in the first place, which implies that he may work a 9-to-5 job. Many do, but many do not as well. (Many men I know work 10 to 12-hour shifts, especially when [or even because] their wives are pregnant, and eat dinner very late at night.)

The second appearance of men is in the subtext drawn from cultural scripts of gendered labor, where men are providers. In other words, the readers (ostensibly women) are told to do things that in reality are more likely to be done by their husbands. For instance, leading up to labor and delivery, women (and their advisors) are encouraged to ready themselves for labor by collecting the things they will need for labor and delivery: clean towels, soap, the *carnet*, and money for services and prescription medications. “Save money for urgent expenses,” it tells them. This money undoubtedly comes from the husband. Similarly, in the third implication of men, the parents are told that after the birth of their child, they need to declare the birth to the state as soon as possible. This bureaucratic and costly process is, in practice, the responsibility of the new father. Finally, and as I will discuss later in this chapter, men are present in their

absence. That the *carnet* does not call upon men to take up specific responsibilities suggests that men do not need to be bothered with “*affaire-u-jiggeen*.”

***Bajenu Gox* (Neighborhood Bajen)**

Another important state-mandated resource for pregnant women is the program called *Bajenu Gox*, or “neighborhood *bajen*”¹³. Started in 2009 by then-President Abdoulaye Wade, the *Bajenu Gox* initiative is a training program for women – usually older, preferably with experience, local knowledge, and social standing in their communities – to learn all the things one would expect of a reproductive and sexual health counselor and doula. The *Bajenu Gox* training manual, last published in 2010, begins by situating the program into global and then state health discourse, first by outlining the United Nations’ Millennium Development Goals (specifically MDG 4 and MDG 5) and then by summarizing conclusions of the annual *Enquêtes Démographiques et Sanitaires* (Demographic and Health Surveys) which show that Senegal wasn’t even close to being on track to meet the MDGs by 2015. The state identified a major problem: even though Senegal was receiving substantial amounts of foreign funding for maternal and child health promoting resources, there was still a significant gap in treatment-seeking. In essence, the theory behind *Bajenu Gox* is that if they couldn’t get women to go to clinics, the clinics would, in a way, go to them.

On the face of it, *Bajenu Gox* is an apolitical organization of community health workers. *Bajenu gox* are not medical professionals, nor are they paid. The mandated responsibility of the

¹³ I debate whether to translate the term as “neighborhood aunt” or “neighborhood bajen.” The term aunt does not capture the importance of the role as a bajen is distinct from an aunt. In popular parlance, the term *bajen* can refer to a father’s eldest sister or to a community health worker in the *Bajenu Gox* program. To distinguish the two in this text, I use the word *bajen* to refer to the generic kin term, the lowercase *bajenu gox* to refer to the community workers, and the capitalized *Bajenu Gox* to refer to the program. The terms *bajen* and *bajenu gox* can be singular or plural.

bajenu gox is to teach women about “behaviors that are favorable for the health of the mother, the newborn, and children under 5 years old.” In practice, *bajenu gox* do much more. The job of the *bajenu gox* requires them to know everyone in their quarter and educate young people and couples about reproductive health (like family planning and HIV/AIDS testing), pregnancy, labor and delivery, and childrearing (like breastfeeding, child nutrition, and vaccinations). They are, in a sense, walking *carnets*, without the medical records-keeping. More importantly, a *bajenu gox* can come when called in an emergency, recognize obstetric emergencies, and go with women to the clinic or hospital and report important family history to a nurse or midwife that might not otherwise get reported. But as Maes writes, “CHWs are political and moral actors who participate in complex relationships with others often seeking forms of change in their own job conditions and livelihoods, as well as various other social, political, and economic changes” (2015:2). Through *Bajenu Gox*, the state draws on compelling kin-politics to reach as many women (and men to some extent) of reproductive age. It’s right there in the name.

Bajenu gox is term that literally means “bajen of the neighborhood.” As explored in Chapter 5, the father’s eldest sister¹⁴ occupies a very important place in in local Wolof kinship: She counsils her brother, supervises her brother’s wife (to whom she is *njèkke*), is a godmother to their children, mediates conflict in the family, and supports them emotionally. To be a *bajen* for the quarter, then, is quite a responsibility. The intervention of appointing a *bajenu gox* in each quarter of Dakar and beyond and giving her specialized training is a culturally appropriate and easily recognizable strategy to disseminate important medical and health information. This co-opting of culturally significant kin relationships is not unique to Senegal. Shanti Parikh has

¹⁴ The term “*bajen*” does not distinguish between agnatic and uterine siblings. Furthermore, because parallel cousins of the same generation are considered siblings, a *bajen* can also be a father’s female cousin.

described a similar situation in Uganda in the late 1990s, where the role of *sôngá* (Basoga: paternal aunt) as a sexual educator to the daughters of her brother had been repackaged and commercialized as a sexual advisor in popular media (like radio, magazines, and TV) called the *ssenga* (a Luganda term similar to *sôngá*) (2015:133-7). Unlike the case of the *sôngá*, it is not the role of *bajen* that is mobilized in *Bajenu Gox*, but the social position and respect that *bajen* receive broadly. If the state wants citizens to receive and follow through on particular information, *bajen* is an obvious choice of what to call their messengers.

One of the objectives of the *Bajenu Gox* program, according to the manual, is “To develop strategies to involve men, mothers-in-law, and/or grandmothers in the search for care for women during pregnancy, childbirth, and after for newborns and children under 5 years old.” Yet, there is little else to say of men in the manual, save for one bullet-point about community outreach. “Advocacy is undertaken to facilitate relations between communities, health structures, and local collectives.” That advocacy includes the task, “To encourage men and other members of the family to support women during pregnancy, birth, and the postnatal period.” Strategies include explaining to men why *planning familiale* (family planning) is advantageous for his wife, himself, his family, and his community. Advantages for him are all resource oriented: “gaining time to prepare materially and financially to welcome the next child,” “reducing the expenses linked to sickness of mother and child,” “reducing work absences linked to sickness of mother and child,” and “having the ability to reorient resources to increase the quality of living for the family, like food, education, living, and clothes.” Beyond that task, *bajenu gox* are expected to take up all the responsibilities that one would expect from a Senegalese woman’s entourage – “encourage, orient, and if possible, accompany a pregnant woman to her four CPNs (*consultations pre-natal*).”

The program itself has been wildly popular with donors, particularly as it offers resources in the interior of the country where health posts are fewer and further between and more difficult to navigate, especially if people have less experience with them than do city-dwellers.. A simple Google search pulls up a number of beaming English-language articles about the program from various international foundations who have donated as well as media outlets (cf. Quist-Arcton 2011). In 2018, I was able to attend the first annual weeklong “*Semaine de la santé de la mere et de l’enfant*” (Maternal and Child Health Week) in Dakar, which was hosted by the Ministry of Health and Social Action (MSAS) and its subdivision, the Direction of Maternal and Child Health (DSME) and sponsored by many of the same foreign donors mentioned on the back of the *carnet*. Along with various panels, seminars, information booths, and free health screenings for pregnant women, new mothers, and children, there was also an event to recognize the *Bajenu Gox* from across Senegal. Hundreds of women in white boubous paraded through the *Place de l’obelisque*, where the event was held. There are little if any stats publicly available on the efficacy or evaluation of the *Bajenu Gox* program, but it is clear from the way they are celebrated by the state, midwives, and expectant couples in my research that the program is popular in Dakar.

During my work in 2016, there was some talk in the MSAS, specifically the DSME which is the branch under which the *Bajenu Gox* program falls, about starting a new twin program called *Nijaayu Gox*, or neighborhood uncles¹⁵, for counseling men. While I was conducting research, the term “nijaayu gox” appeared in two publicly available documents that I was able to track down, both published in 2016, but nothing has appeared since.

¹⁵ “Nijaay” is a term that refers to the mother’s brother. There is no distinction between agnatic and uterine siblings in this role. Similarly to the *bajen*, a *nijaay* may also be a mother’s male parallel cousin.

The first was released by STEP-UP, an organization that specifically deals with unintended pregnancy. Titled “*Rencontre de partage sur la problématique des grossesses non désirées chez les adolescents/jeunes au Sénégal*” (“A Meeting on the problem of unwanted pregnancies among adolescents and young people of Senegal”) is a meeting report of a June 2015 workshop held by representatives of DSME, Partners in Population and Development Africa Regional Office, and the Population Council. The meeting was to discuss the results of a report called “Understanding Unwanted Pregnancy in Senegal: A Country Profile.” In the meeting minutes of this workshop, under the heading of “Brainstorming Session,” there is a single bullet-point among ten which reads “Involving men, notably by replicating the initiative ‘Bajenu Gox’ into the initiative ‘Nijaayu Gox’ so as to involve men as agents of community advocacy.” There is no further description of what might distinguish the two or why a program for men is needed.

The second appeared in a National Strategic Committee of Family Planning (CSNPF) prospectus on the implementation of new programs and bolstering of existing ones into 2020. Under the category of “Priority Interventions,” one objective is the “Reinforcement of [public] communication targeting men,” and includes increasing the Ministry of Health’s reach through various religious alliances, workshops, and broadcast conferences and discussions about family planning. New initiatives were concerned with going to where the men are: social media (Twitter and Facebook), holding public health responsabilization seminars in the workplace, and “expanding ‘Nijaayu Gox to the 14 regions [of Senegal] and organizing orientation workshops of Nijaayu Gox on [reproductive health and family planning].” There is no mention of where they are expanding *from*, but I wondered if there was a pilot program somewhere in the country that I could investigate. When I bring this up to officials in the MSAS and DSME, they just laugh.

“Never heard of it, but *there’s* an idea,” one remarked. No one that I’ve raised *Nijaayu Gox* to knows what I’m talking about. It’s also unclear who, in both reports, brought up the idea (or if they are the same person), so it is as yet not possible to contact them. What is apparent is that someone believed that addressing men’s involvement was worthy of starting up an entirely new state campaign but that it hasn’t had any traction. I suspect this is because *Bajenu Gox* co-opts a distinct category of cultural authority – the *bajen* – that the *Nijaayu Gox* would not. The two are not equivalent.

The Rhetoric of the Carnet

The *carnet* is a multi-purpose tool of the state: it both documents and safeguards personal medical information while also directing pregnant women on how to be good and safe pregnant subjects (and, later, maternal subjects). With respect to the latter mechanism, it also serves to give men a basis for *surveilling* their pregnant wives, which I’ll discuss below. I take “surveillance” in its literal (French) form: *sur* (over) + *veiller* (to watch), or “to watch over.” (*Veiller*, unlike other terms for watching [like *regarder*], also has the connotation of “to ensure.”) I do this for two reasons. First, *veiller* is the verb that men use to describe their activities. “I watch (*je veille*) that she eats right.” Second, *surveillance* demonstrates and reaffirms that men are carrying out the task of watching *from above*. They do this in two senses: as gendered household authorities (not merely men, but men vested with cultural power) and as agents of state healthcare. Certainly, men have always already been dominant in Senegalese households and Senegalese institutions are, by and large, dominated by men. What I mean to argue here is that the *carnet*, authored and approved by state and global institutions, fits with the pre-existing form of masculine domination in the Senegalese household. I will explain this below.

According to Sallie Han's (2015) ethnographic research in the United States among middle-class pregnant women, reading pregnancy texts (such as guides, manuals, and self-help books) shapes women's experiences of pregnancy and influences how they feel toward pregnancy and their unborn child. Han's argument moves beyond the critique that women are necessarily policed by the texts, rather she is interested in how literacy and texts shape women's experiences. Han writes, "Policing describes how others impose their expectations and experiences on women" (2013:31). However, I think the question of policing is an important critique to make in the Senegalese context where women have fewer and more homogenous informational resources – and I include *Bajenu Gox* here – thanks to different state programs which must more or less be in agreement with one another. As Foucault (1975) famously argued, it is (self)policing and surveillance that enforces idealized social norms to further a particular goal – in this case, ameliorating maternal and infant health metrics. Han, on the other hand, is working in a context where pregnancy texts are disparate and heterogeneous, authored over generations by many different stakeholders with often competing and contradictory advices about what an "ordinary pregnancy" (as Han puts it) might be. The authors of the texts which Han's interlocutors are reading are probably aware that they are in competition with other authors and texts, while the Senegalese state is acting under the influence of global health organizations and foreign governments to mobilize discipline and surveillance. The women in her study may have to reconcile some kinds of advice with others and can seek second opinions from various physicians, birth workers, or just experienced friends, while in Senegal the conventional wisdom is much more homogenous and second opinions often come from YouTube and expatriated female relatives.

One particularly salient way that advice and intervention is unfolding is in the specialized *accouchement humanisé* (humanized birth, or AH) delivery room at *Hôpital Central* in Dakar (also known as *Salles d'accouchement à style libre*, or “free-style delivery rooms”). A 2018 study by Japan International Cooperation Agency (JICA), the Japanese developmental aid organization that introduced AH to Dakar, shows that as many as 70% of women who delivered in the AH salon did so in a lithotomy position (MSAS 2018:31) – on their backs with their knees up and apart. A central philosophy of AH is that women can give labor however they want and in total privacy – “They can cry, scream, walk around, vomit, shit in the corner, whatever!” one midwife told me. It was surprising to learn from the JICA study that women would default to giving birth on their backs, but I surmised that childbirth classes that might instruct them about their options probably weren’t available (they weren’t), nor were there any kinds of educational materials that women could read or look at as they neared the end of their pregnancies. AH as an explicit concept is not mentioned in the *carnet*. The only instruction that women received was in their final CPN. Midwives explain the concept of AH and show women illustrations of birth positions, and then ask which position interests them most. When women arrive to give birth, they are reminded of the position they chose (which is marked in their *carnet*) and they undergo a brief physical examination to make sure it is safe to give birth in the chosen position. When I investigated why women were likely to give birth on their backs, midwives told me “That’s just what [the women] know.” During childbirth, I am told, midwives seldom instruct women that they can give birth in other, perhaps more comfortable positions.



Affiche Bâche/Papier-
Prestataire

Affiche Bâche ASL

Figure 6.3. The birthing positions that women are shown and offered at their final CPN.

According to Marika Seigel (2014), pregnancy manuals in the United States are a kind of technical communication concerned with procedure and instruction, much like the manual of a machine or household appliance. It identifies the pregnant person as a “user of the technological system of prenatal care” which includes medical professionals, medical care, and medical testing to which one must submit. The manual advises on much more than these things, however, such as prescriptions and proscriptions for nutrition, physical labor, and the kinds of things to expect from one’s own body.

To situate the *carnet* here, it is much less about “advice” and more about “instruction,” the difference between the two being a difference of what is imperative. It, too, is less a guide than a manual, because it has a unique, state-mandated, political-economic history (and foreign donor sponsorship evident on the back cover); it is not privately authored or sold in retail stores. That the *carnet* is more a manual than advice is evidenced by the fact that so many people claim

to “turn to the *carnet*” when they don’t know something, even while they have an entourage around them to help if they need it. It is also true that men are less likely, by admission, to seek out that knowledge directly from women because “pregnancy is women’s business,” and in that way, the *carnet* gives them a chance to seek it out discreetly.

Seigel contends that pregnancy manuals are written from a functional rather than critical perspective. They assume that the “user” “can, should, and needs to use the prenatal care system and be used by it (rather than negotiate that system)” (20-1). Troubleshooting risky bodies means submitting to technological systems and healthcare specialists and always following their directives. From the user-side, this shows up in Dakar where one of the most repeated important things a pregnant woman can do is follow her appointments and do what the midwives say. From the manual side, this makes sense for the *carnet*, as it is authored by the state and distributed in health centers – they would not distribute manuals that are “system-disruptive,” especially when one of the most major concerns in DSME is simply getting women to give birth in a hospital.

Because Seigel’s research context is American, she’s not particularly concerned (or is overlooking) the relationship between the user and the people around them. Here, again, pregnancy is located in the individual pregnant body, rather than a social network or a set of social relationships. The manual reframes and rearranges social roles by directing pregnant women to practice pregnancy in different ways than they do their non-pregnant lives. When pregnant women, particularly in tight-knit social webs of multi-generational and often times polygamous households in Dakar, shift their social roles, the rest of the web must shift with them – at least those closest to her. This would happen with or without the manual, but the manual is the state’s prescribed way of doing so in order to maximize health outcomes for the mother and

fetus based on input from foreign donors and sponsors. In other words, the *carnet* is a powerful tool, not just of global health discourse, but of social engineering as well.

Seigel provides a powerful way of looking at the *carnet* by identifying what she calls “pieties” and “articulations” (23). Pieties are suggestive about what a user can and should do to be successful, whatever that may mean. Pieties shape the identity of the user in that they direct users toward using things in adherence with a particular protocol. Reading into the pieties of a manual can tell us about who the manual authors think the audience is and should be. As an example, Seigel shows us a photo from a blender manual in which a manicured hand is placing the lid on the blender, “a sense of what properly goes with what”: a woman cooks in the home. If the pieties in a manual illustrate that a pregnant woman “eats this, not that,” “continues this domestic labor, not that labor,” and so forth, then the identity of “pregnant woman” is *articulated* to those practices. Thus, the state (and by extension, global health discourse) harnesses the technology of the *carnet* in the process of pregnant subject-making.

The logos on the cover and the back of the *carnet*, as well as the venue in which they receive it (i.e. the maternity ward), and who they receive it from are all parts of a suite of symbols that communicate authority about its contents. This is reflected in the way that men and women talk about the *carnet* or refer to things that are in the *carnet* (without referring to the *carnet* specifically). An unintended consequence of making pregnant subjects in an ideal form was the effect (and affect) that it has on expectant fathers. It is not that men do not see themselves in the *carnet* or what *bajenu gox* and midwives may have to advise them on, rather that they *do* see that they *are not* there. By omitting men from the state’s ideal picture of maternal health and subjects (beyond the covers of the manuals), the state reinforces the idea that men are not a part of the worlds of pregnancy, prenatal care, or childbirth and delivery that

women inhabit. The state, through its authoritative position on crafting ideal citizens, reinforces that pregnancy really is “women’s business.”

Despite a lack of representation in the *carnet*, men do read the booklet. Sometimes they read it because their wives are not literate or fluent in French, sometimes they read it because they want to know what is going on with their partners, and sometimes they read it because it gives them a sneak-peek into a sort of forbidden realm of gendered knowledge that they would be too embarrassed to get directly from the source. In any case, the *carnet* gives them an essential list of guidelines by which women can be surveilled and disciplined into healthy pregnant subjects.

Often, when talking to men about what they do during pregnancy, a typical response might be to call pregnancy “women’s business” and add that their partners have their *goro* (mother-in-law), *njèkke* (sister-in-law), or other women to take care of them. When pre-conditioning men with ideas of what anyone can do to take care of pregnant women, men will agree that “finding money” (*chercher l’argent*, and all the activities that involve money, like paying for medications and consultations) and “emotional support” (*soutien émotionnel*, such as keeping her in good spirits, not letting her feel alone, teasing her) are things that men are expected to do. Beyond these two categories, men will also typically add sentences that start with “I make sure...” or “I watch...” (*je veille*, in both cases) – “I make sure she eats x, y, or z” but also “I make sure she does *not* eat a, b, or c,” for instance. The surveillance – *watching over* – also includes how she dresses (in loose, comfortable clothing), her physical activity (some, but not too much), her rest (that she sleeps and sleeps *well*), and more. All of these prescriptions and prescriptions are in the *carnet* and the *Bajenu Gox* training manual. The *carnet* has universal acceptance among our interviewees – men and women – as an indispensable resource for

expectant couples. Some, both men and women, even talk about it in terms that evoke a holy text. When asked what people thought of the *carnet*, if they found it useful, some might respond positively. “If I don’t know something, I just go to the *carnet*!” If men in particular couldn’t answer a question like “What should your wife eat or avoid eating?” they were likely to say, “I don’t really know, but it’s in the *carnet*.” Conversely, if I asked why women were obligated or forbidden from eating or doing something, men would typically say, “I read it in the *carnet*” or “That’s what the *bajenu gox* told us” (in addition to other responses like, “I learned it from my mom” or “It’s what I’ve seen other pregnant women do”).

Similar ethnographic research by Campell and Shaw (2008) with intravenous drug users (IDU) has shown how IDUs have taken up the language of ethnographers who studied them to refigure themselves as “ethical subjects.” In their research, the ethnographers who interface with them are viewed as authorities who decide what “ethical” is, and the IDUs adhere themselves to that construction. The *carnet* and *Bajenu Gox* are mechanisms through which the Senegalese state is able to wield that power on a much grander scale. Unlike Campbell and Shaw’s work, however, the articulations and pieties of the state programs get bootstrapped to local conceptions of gender and kinship that increase the scale and efficacy of such state controls.

In the Muslim household, the *kilifa* – the head-of-household, almost always a man – is responsible for the well-being of everyone in the house. The *carnet*, in a way, acts as a both a tool of ensuring well-being (by knowing *what constitutes* well-being) and as a mechanism of distancing one’s-(masculine)-self from too much involvement (because he, himself, is never implicated in the directives of the *carnet* or by the *bajenu gox*). In this way, men are involved without being *too* involved. They maintain ignorance of the process, but they can express governance. They are simultaneously active and inactive. They are expressing, to paraphrase

M'charek and colleagues (2014a, 2014b), “absent presence” in that role. And whether or not this was intentional on the part of the state, it is remarkably effective at getting women to keep their appointments, which was one of the state’s primary goals. Men’s surveillance over their wives is similarly documented by the anthropologist Dinah Hannaford (2015). In her research, women in Senegal with husbands who had migrated abroad for work kept in regular contact under the auspices of maintaining emotional closeness, while giving the feeling of suspicion. In my work, however, women reported that they found their partners’ questions and phone calls reassuring, and that they were a sign that he cared.

CRSD

The state *carnet* gets folded into local pregnancy landscapes and in men’s engagements with pregnant partners in various ways. One way that men are encouraged to surveil their pregnant wives is in what they hear from their imams. In a downward trickle of state-health information, the state, once the *carnet* is published, workshops with it various organizations who work to promote the *carnet* and the information therein. One such nongovernmental organization that I encountered during research, and a prolific one at that, is the *Cadre des Religieux pour la Santé et le Développement* (Religious Group for Health and Development, or CRSD) – an interfaith religious organization concerned with population and reproductive health matters in Senegal and West Africa more broadly. CRSD played a significant role in getting the finished product of the *carnet* into the hands of Senegalese people, which is contiguous with a decades (maybe century?) long tradition of partnership between secular and religious authorities in Senegal in matters of democracy and health (a partnership they tout in their own published educational materials, which I describe below).

In one facet of their work, CRSD coordinates with the DSME on issues of reproductive health programming and messaging and they are funded principally by the William and Flora Hewlett Foundation and the World Faiths Development Dialogue at Georgetown University. One example of CRSD's mission is that they host professional workshops with other local religious leaders to discuss theological underpinnings of reproductive health with an emphasis on birth control: birth-spacing, condom-use, and contraceptives (also called *planning familial* or PF). Birth-spacing and condom-use are acceptable in Islam (according to CRSD) because they require the consent of both partners, while the acceptance of contraceptives (e.g. pills, IUDs, and implants) is debatable because those forms of birth control can be carried out clandestinely. Marital agreement is a prime concern for these issues, but when it comes to the trickiest ethical dilemmas, it is widely agreed in the CRSD that the decision which saves the most lives is the right decision¹⁶. (In other words, in some limited circumstances, it would be acceptable for the sake of woman's life as well as those of her current and potential children if she were to clandestinely seek out and use PF.) Once the CRSD puts together their theological argumentation for PF, for example, they meet with religious leaders around the country who then integrate the conclusions of those workshops into their sermons, the advice they give their congregations, and the things they say in print, radio, and television.

When I met with Cheikh Saliou Mbacké, President of the CRSD, I told him that in my research, there were many men who considered themselves to care "distantly" for the health of their wives – that is, they wanted their wives to be healthy and happy, but they relied on their wife's entourage to put it into action. How does one convince these men to take up more active

¹⁶ This ethical consideration is not limited to CRSD. It is also found in Abdulaziz Sachedina's 2013 "Islamic Biomedical Ethics," which is widely regarded as the authority on the topic in English-speaking medical schools in Muslim countries.

roles, I wondered. “Men must care for their wives actively, because the Prophet cared for his wives,” he responded. There was no telling whether this reasoning actually worked – he made it sound so easy. What does work, however, is when men hear their imams speak positively about women’s health and birth control. Okigbo and colleagues (2015) have shown that in Senegal, imams’ sermons, radio, and television programming can have considerable sway over men’s attitudes with respect to women’s reproductive health, going as far as taking responsibility for purchasing and carrying condoms (which is highly significant in a country where women are expected to do so but have considerable problems accessing the things they need).

Looking at CRSD materials through the rhetorical lens, one can apply the same concepts of articulation and piety. In one passage of the pamphlet *Argumentaire Islamique sur l’Espacement des Naissances* (Islamic Argumentation for Birth Spacing), the author interpellates the readers as “Dear Muslim brothers,” taking into good faith that the audience is composed of like-minded believers who are men. They continue, “It is the obligation of everyone to adjust the size of the family to your financial means in order to avoid failing into extreme poverty and to preserve the health of the mother and the children. It is by that, only, that we may be the best heads of our families” (CRSD 2015:22). The piety lies in “the obligation of everyone,” and “that we may be the best heads of our families.” In other words, being a good Muslim requires that one maintain household well-being and financial security, and the way to achieve those goals is to, as they say, “organize” the births to fit those needs. Further, the above-mentioned invocation of the Prophet is also a piety. By appealing to scripture, the CRSD is able to draw men in by invoking the goal of being like (or “near”) the Prophet. The same strategy is employed in the material on ‘Azl, or *coitus interruptus*, a method of PF used by the Prophet. “‘Azl’ was practiced at the time of the Prophet,” the pamphlet says (2015:12-3) in defense of PF and it goes on to

argue that as technology advances, we have new methods of contraceptives that essentially accomplish the same thing.

CRSD has been remarkably efficient and successful in achieving their goals. The organization knows why and they are exceptionally judicious in their exploitation of that reason. “Many people in Senegal listen only to their religious advisors,” they say. “Even politicians know this, because they’re always seeking our endorsements from religious leaders. It’s important to understand this, because you [imams] can make a difference” [2015:26].

It is in this context that the CRSD was asked to participate in a training workshop directed by the DSME to learn about the then-newly published *carnet* so that they could then carry that information forward to religious leaders in Dakar who in turn “spread the word to the people.” Given the country’s remarkable history of fighting HIV/AIDS (Meda et al 1999), supporting peaceful democratic elections and transfers of power (Diouf 2003, Gellar 1995), and a recent study showing that men are more open to taking responsibility for contraceptive access and use when they hear their imams endorse those things (Okigbo et al 2015), it is unsurprising that the Ministry would employ religious authorities to help them disseminate important maternal and child health information¹⁷.

Conclusion: Globalizing Gendered Pregnancy

¹⁷ There have been multiple failed attempts to launch digital carnets in the form of mobile phone apps in Senegal, namely “CAR-NET” in 2007 and “Mommy’s Book” in 2014. CAR-NET was developed by the French firm Mallyance while Mommy’s Book was developed for the medical organization *L’agence Panafricaine de Développement et de Promotion du Médicament* and their website *santetropicale.com*. Neither were developed in Senegal nor were they developed for a specifically Senegalese context nor were they developed in any of Senegal’s local languages. Not only are mobile apps relatively expensive for the average Senegalese, they can be costly in terms of data and bandwidth. These factors all contribute to the fact that neither of the apps took off in Senegal, but without buy-in from religious authorities, those projects were likely dead before they started.

Not long after I arrived in Dakar, I was speaking with my colleague, Adama Kane Faza. Adama is a highly educated, middle class Senegalese architect and artist who was bouncing around Europe at the time for work. We were talking over Facebook about what I was doing back in Dakar (“*this time*”). I told him I was doing research for my dissertation that would eventually become a book. “In fact, I think it’d be great if you designed the cover of my book when that day comes,” I nudged. He fired back, “Have you seen this?” with a photograph of a freshly-published copy of “*Grossesse et maternité: Expérience de deux Afropolitaines*” (Pregnancy and maternity: Experiences of two Afropolitaines). It was about to be released in local bookstores and there would be a book-launch party a few weeks later. Adama had designed the cover and all the illustrations inside. Not only was he establishing his experience with artistic publication, but that he had already done a book about women’s perspectives of pregnancy. He was happy to help me with my own book on men’s perspectives. I was thrilled.

I rushed out to the bookstore as soon as it arrived. (The French salesperson was highly suspicious that I – a white man – was so enthusiastic about buying a pregnancy guide by and ostensibly for African women.) Aminata Ndiaye Tall, a Senegalese woman living in the United States, and Yacine Bio-Tchané, a Beninoise woman living in Cotonou, co-authored the work from their experiences as mothers in West Africa. It reads very much like an American or French pregnancy guide – and with the usual blank spaces where pregnant women can journal their experiences alongside the authors’ – except there is a particularly West African perspective and context. The book is much more likely and willing to implicate community support and it’s more open about the uses of spiritual tools (like *gris-gris*). There is little if any mention of men, and almost nothing about recognizing obstetric emergencies or pregnancy loss. The authors seemingly take for granted from chapter to chapter that the health of expectant mother and her

fetus are progressing “normally.” Like the *carnet*, the book requires French literacy – a skill most Dakarise women do not possess – and the price is about \$20, plus the cost of transportation to and from a bookstore. It has a decidedly middle-class audience, which falls outside the purview of my own research.

Additionally, YouTube videos are readily accessible in Dakar. The youngest participants (18-22) reported looking to YouTube for pregnancy advice¹⁸. While I did not view the videos they referred to, what they reported learning was not different from what they would have learned from the *carnet*. In all cases, YouTube was helpful because they could not read the *carnet*, and some mentioned that watching YouTube videos with their husband or partner was a bonding experience through which they learned together.

This chapter may give the impression that the state, in partnership with donors, NGOs, and other organizations, has a stranglehold over gendered knowledge and subject-making through programs like the *carnet* and *Bajenu Gox* as well as strategic alliances with CRSD and JICA. As I’ve described, that power is intelligently wielded through the appropriate local values, like kinship (*Bajenu Gox*) and religion (CRSD). But there is a relatively small and growing grassroots trend that could upset the state’s influence – like YouTube videos and privately-authored pregnancy manuals. More importantly, however, a substantial amount of Senegalese people lives outside of Senegal. (There is no estimate of how many expatriates there are, but it is significant that some estimate that as much as 10% of the nation’s GDP comes from remittances.) Transnational relationships between expectant Senegalese couples and their

¹⁸ We should be careful to understand that using YouTube should not be considered a bourgeois luxury (like G&M) as cellular service and data plans, while somewhat expensive, are widely accessible to lower/working class Dakarois – if not on one’s own mobile device, then on a friend or neighbor’s. (Just to hammer home this point, people will make sure their internet/phone is charged [with credit] before spending on seemingly more pressing things, like utility bills. The need to stay connected is very important.)

expatriated relatives surely play some role in modifying the practices and expectations of Senegalese pregnancy (Hannaford 2015, Sargent 2006). Finally, European and American television shows and films play regularly on Senegalese channels which undoubtedly deliver different expectations about pregnancy into Senegalese homes. In general, men have often remarked on American masculinity from what they know of Jack Bauer, the protagonist of 24, a very popular American television show that plays in Senegal. In particular, as expectant fathers, men have also told me in some form that they aren't like "white people" – recall from Chapter 4 that Cheikh, a man who'd never left Senegambia, told me he did not see himself going out to buy clothes and goods for his unborn child "like white people do." I look forward to seeing how external forces like mass-media and transnational migration challenge gendered knowledge and prenatal care in the future.



Chapter 7: USAID and “Men’s Involvement”: How Development Produces Gender

Xamul aay na wante laaj te wela ko yées.
(Not knowing is bad, but not asking is worse.)
– Wolof proverb

In this chapter, I elaborate on the core motivation of this dissertation project – that meaningful reporting and scholarship about the experiences and perspectives of expectant fathers are systematically effaced from global health programming and scholarship. I do so by looking at the mechanism by which gender is produced and shaped by global health and development discourse. In particular, I look to the propaganda tactics of development reports that imagine and dictate global, context-independent gender issues. What is equally important to consider here is not that organizations like USAID get to define gender (and it’s debatable that they actually do), rather that, following Gayatri Spivak, in the domain of global health and development discourse, Brown women *cannot*.

I begin with a USAID report (“DHS 64”) released in 2018 regarding “men’s involvement” in women and children’s health, and how the report defines involvement. This specific report is salient to my ethnographic research, in that it accurately characterizes what Dakarais men do *not* do, but by missing the important roles that men play, concludes with the implication that men are not involved in women and children’s health.

Following my discussion of DHS 64, I’ll give a brief contextual summary of the historical project of how gender is produced through and shaped by development discourse. This includes looking at USAID’s concept of “gender mainstreaming,” in the 2007 document “Gender Terminology,” and the USAID’s 2012 “Gender Equality and Female Empowerment Policy” as

rhetorical artifacts of “devthink.” Finally, I return to the USAID report on “men’s involvement” to highlight how through erroneous conclusions that men are in need of education and sensitization toward women and children’s health instead of targeting the more acute causes of maternal and child morbidity and mortality at the state-level, DHS 64 is actually harmful to women and children. I argue, following the works of Ferguson and Escobar, that as development logics follow from (and overlapped with) colonial discourses, programming that targets men-as-obstacles, rather than men-as-gendered-agents, aims not to succeed at stated project goals, but at extending governance over social life.

DHS 64

As luck would have it, smack-dab in the middle of my dissertation research, USAID released a report titled, “Does Men’s Involvement Improve the Health Outcomes of their Partners and Children? (DHS Analytical Studies 64)” (Assaf and Davis 2018, hereafter “DHS 64”). In it, the authors use Demographic and Health Survey (DHS) datasets from 33 countries to correlate men’s survey responses on outcomes of family planning, maternity, and child health with “men’s involvement.” The key indicators in the study are defined as “correct knowledge, positive attitudes, and supportive behaviors toward the health of their partners and children.” The statistical indicators that they use to constitute “correct” knowledge, “positive” attitudes, and “supportive” behaviors are deliberately chosen to obfuscate locally particular forms of prenatal care, as supported by my ethnographic data which fundamentally challenge the report’s key findings. “Men’s knowledge,” for instance is measured by whether men know to give children water when they have diarrhea or have correct knowledge of his partner’s menstrual cycle; “men’s attitudes” are measured by whether a man disagrees that contraception is only a woman’s

business or that women who use contraception become promiscuous; “men’s behaviors” are measured by whether a man is present during any one of the antenatal clinical check-ups or if he has discussed family planning with a health worker. Senegalese men’s involvement ranks fairly low across the board.

The authors of the report conclude with a number of analytical and statistical limitations, specifically that the surveys were country-specific which made comparison difficult, and that many of the variables alone did not have significant correlation with women and children’s health outcomes. (The authors did not produce a multivariate analysis.) In the Discussion, they speculate that perhaps there is no significant link between attending prenatal clinical visits and health outcomes because perhaps “men report that they attended [prenatal clinical visits] in order to appear favorable to the interviewer” and that “this could also have been the case for the other men’s variables related to their knowledge, attitudes, and behavior” (39).

While the authors trouble their own methodologies, the conjecture that men were lying (globally, it should be added) betrays their own expectation that men’s involvement does influence women and children’s health and a refusal to accept their own findings. Thus, they nonetheless gesture that “Gender transformative interventions that include educating men through discussion with health care providers have also been found to result in greater attendance and male participation in [prenatal clinical visits]” (39). The suggestion that the answer is educating men (a justification for the existence of global health programs and additional studies) comes not because of the Discussion section – which itself states that the report is flawed – but because of the poor analytical design and bias of the report that confirmed that men are not involved as the authors define “involvement.” The implied takeaway from the report is not about

correlation, but that men are not involved, or worse yet, that they aren't concerned about the health of their partners and children.

It is true that men are not involved as DHS 64 defines “involvement.” There are two problems with this. First of all, as this dissertation demonstrates, Dakarois men do not rank highly according to DHS 64's definition of “involvement” for justifiable reasons. According to DHS 64, 80% of Senegalese men do not attend prenatal appointments (CPNs) with their partners, ranking just second from the bottom before Burundi. My ethnographic data shows that (a) they're likely working (i.e. “finding the money”), sometimes undertaking migrant labor in the interior of the country, (b) they aren't wanted in those spaces, either by their partner, their mother (*goro*), or their sister (*njėkke*), and (c) they find that being the only man in room of pregnant women and their *accompagnants* deeply uncomfortable. DHS 64 also finds that only 5% of Senegalese men surveyed reported discussing family planning with a health worker. In addition to the reasons for not attending CPNs, my interviews with men have broadly demonstrated that when men attempt to approach nurses, midwives, and doctors for information or advice, they are told little or nothing, and even ignored. It should seem counterintuitive to the authors that Senegal ranks fairly high on the question of whether men “agree that contraception is only women's business”; about 90% of Senegalese men surveyed do not agree. The report makes no indication of why men may make contraception their business but not discuss it with health workers. This is simply because the decision to use contraception is a matter for the couple to decide on jointly (as discussed in Chapter 6).

My ethnographic material demonstrates that men do involve themselves in other, profoundly important ways which the DHS does not track. The statistical indicators comprising DHS 64's “men's involvement” (and likewise, the questions asked in the DHS itself) are drawn

from certain assumptions about the universality of gendered labor of care, which are informed by Western notions of “men’s involvement,” and women’s rights more broadly. Rather than involving themselves in the neoliberal, biomedically-focused forms of care that DHS 64 suggests constitute “involvement,” men, as discussed in Chapter 4, involve themselves by funding the expenses of pregnancy, childbirth, and the *ngente* and by providing emotional support through presence (sometimes *absent* presence, in the case of migrant men who call daily), surveillance, and the performance of financial support.

The DHS data from which the USAID analysis is drawn (*Sénégal: Enquête Démographique et de Santé Continue 2016*) are also incomplete partly because the Demographic and Health Surveys are designed to survey *global* health, one country at a time, and are therefore not culturally particular to a specific setting. The authors do indicate that the surveys are country-specific, but I would argue (as they do) that the differences between country-specific survey datasets are necessarily flattened to make global claims, and that country-specific surveys tells us little about a multi-ethnic, multi-lingual country like Senegal. The authors of DHS 64 do intimate toward sensitizing future DHS surveys to locally-particular cultural practices and expectations. While that would be more useful to those interested in locally nuanced, fine-grained data, based on how cross-sectional country-specific datasets get homogenized, I have little faith expanding the DHS even more would be effective.

The second problem with DHS 64’s claim that men are not “involved” is that the expectation that men’s involvement (in any form) would correlate with women and children’s health outcomes follows from a presumption that partners, husbands, and fathers are the sole care-providers of their partners, wives, and children. As my work in Dakar demonstrates, particularly with respect to the *entourage*, this is not case. Simply put, just because expectant

fathers may not engage in the practices of care found in DHS 64 does not mean that no one is. It may be more meaningful to ask, “What forms of involvement improve the health outcomes of their partners and children?” thereby leaving the definition and the agents of involvement open to inquiry. In contrast, when I entered my research in Dakar, I preferred to leave “men’s involvement” undefined and unmeasured, and instead remained open to understanding women’s perspectives and experiences of men’s involvement.

The DHS 64 concept of involvement is severely limited by Western neoliberal imaginations of social relationships: normative family structures are nuclear, and “involvement” or care is operationalized in relation to biomedical notions of somatic health. Further, the characteristics of DHS 64’s “men’s involvement” presuppose an unrealistic, normative or prescriptive model of rational decision-making (cf. Garro 1998), thereby ignoring important and locally-specific context of historical, political, and economic forces that undercut individuals’ ability to make certain therapeutic choices. This is not to suggest that people don’t make rational decisions, but that such models are context-specific, which (again) is not within the purview of DHS or USAID reports. As I mention above, men may not discuss family planning with a health worker if a health worker refuses to engage with them, and they may not go to CPNs if they have to work or don’t feel welcome.

DHS 64 is one document. In order to demonstrate how reports like DHS 64 have the potential to produce and shape gender, it is important to consider how gender is mobilized for the purposes and goals of global health and development, and that given the history, DHS 64 is actually unremarkable. Next, I will (very) briefly review the history of gender in colonial and development discourse and then look to select passages from USAID’s “Gender Equality and

Female Empowerment Policy” and “Gender Terminology” guide before returning to DHS 64 in my conclusion.

Paradigms of Gender Colonialism

Gender has long been deployed as justification for civilizing missions, whether colonial, humanitarian, or both (Escobar 1995; Sharpe and Spivak 2003). The discursive progression from colonial administration to development programs is not unrelated to Spivak’s famous diagnosis of “white men...saving brown women from brown men” (2006). Because women are historically portrayed in terms of reproduction and as care providers, as well as being docile and passive, there has been an overwhelming worldwide effort to empower and protect their reproductive roles, most saliently under the banner of “Safe Motherhood” and more recently under “Reproductive, Maternal, Newborn, Child, and Adolescent Health” (RMNCAH). When one seeks to portray women as needing to be saved, the issue gains a moral valence: women are not only reproducers and care-providers (Escobar 1995:172), they are vested with potentiality – they represent the future (i.e. of a society, of a nation-state, or of humanity). This moral aspect is thus undertaken by social activism movements (such as the National Organization for Women, FEMEN, White Ribbon Alliance, and V-Day), international aid organizations (USAID and JICA, as it concerns this dissertation), and even national militaries (in the case of the War in Afghanistan, for example [Abu-Lughod 2002, 2013]) in what Lila Abu-Lughod has identified as “moral crusades” (2012). What is important about Spivak’s indictment of foreign intervention is that “Brown women” don’t get a say in whether (or how) they are saved.

Over the last century, as Western nations have converted the biopolitical justifications of their foreign presence from one of a *mission civilisatrice* to one of development and

humanitarianism, women's bodies have continued to legitimize foreign intervention. Beginning in the 1980s and well into the 2000s, female circumcision (rhetorically identified as "genital mutilation" [FGM] in development reports) has been a major talking point for not only raising funds, but for fostering xenophobic attitudes in Western nations. (Anthropologists like Barbara Hoffman and Bettina Shell-Duncan have worked to trouble the rhetoric of "FGM." Hoffman, in particular, gives the subaltern voice in her ethnographic film, "Womanhood & Circumcision: Three Maasai Women Have Their Say" [2014].) More recently, obstetric fistula and menstrual hygiene projects have become the new FGM and cause for saving women. Women's bodies and lives have always mobilized missionaries, physicians, educators, militaries, NGOs, and other forms of development aid as saviors, giving them an excuse to intervene, occupy, settle, and extract.

While it is true that colonial and development discourses overlapped from the 1920s through the 1950s (Escobar 1995; Prince 2014; Adams 2016), gender really became a discrete and explicit target of economic development with the 1970 publication of Ester Boserup's "Women's Role in Economic Development." It was from this publication that the first model of women's participation in development emerged, called "Women in Development" (WID). Programs based on the WID model focused solely on women, seeking to augment their economic contribution and integrate them into positions within government and development agencies, but there were many criticisms of WID. In particular, the WID model effectively doubled women's workload by not accounting for their reproductive labor (Escobar 1995:172). In the 1980s, a new model arrived: "Women and Development" (WAD). The WAD model was based on a critical socialist-feminist approach that sought to question the hegemonic development models which were rooted in neoliberal theories of the market economy, i.e.

development through economic growth (Heinonen 2006:39). Moreover, WAD programs acknowledged and accommodated women's roles as mothers and care providers. In opposition to WID, and later WAD, in the 1990s a third model sprang up, which seems to be the longest-lived, "Gender and Development" (GAD; Heinonen 2006:40). The initial aim of proponents of GAD was not to focus on women (or men) in particular, but with a wider scope, on the power relations that manifest between men and women (Heinonen 2006:40). In addition to adopting a wide range of critical and postcolonial feminist theory, it was also under the heading of GAD that development researchers began to investigate women's health and reproductive rights, as well as violence against women (Heinonen 2006:40).

We see this throughout the history of development and global health, but relatively recently the International Conference on Population and Development (ICPD) was hosted in Cairo, Egypt. This is a landmark conference in global reproductive health because, unlike the many conferences preceding the ICPD, many of the goals set in the Programme of Action at the ICPD were gendered, and reproductive health was a major concern. While the Programme encouraged men to take up the cause for gender equality, it did so by urging scholars to appeal to men's rational decision-making and reminding them of their responsibilities as the dominant gender:

Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual, and reproductive behavior, including family planning; prenatal, maternal, and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and

nutrition; and recognition and promotion of the equal value of children of both sexes.

Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children (ICPD Programme of Action, “Male Responsibility and Participation,” 4.27).

This passage assumes several things: first, that men need to be coaxed into responsible parenthood, as well as sexual and reproductive health behavior. Second, that men present risks through their control of family income, through their possibly unequal value placed upon the genders of their children, and through the threat of violence that they pose to women and children. Finally, it assumes that boys are not already inculcated with the concepts of “male responsibility” through lifelong socialization of masculinity. Men, in this paragraph, must be managed. As Sharpe and Spivak have pointed out (2003), the discourse of global feminism has the propensity to universalize women, turning them into homogenous and monolithic “Third World Women” – I would add that it has the same effect on men. Perhaps more importantly, the monolithic figures resonate with what Sarah Willen calls the “discursive blank canvas upon which diverse actors begin to project their own moral values and political emotions” (2010) – a projection without consent or input on the part of those whose bodies are mobilized.

The late postcolonial Marxist scholar Samir Amin has level similar critiques against the UN Millennium Development Goals (of which MDGs 3-5 are aimed at women): while the MDGs are commendable, they are hopelessly vague goals that no one asked for (2006). Amin calls into question the original intent of the MDGs (suggesting they’ve been foisted upon the world through an uncharacteristically rushed fashion [for the UN] in the name of capitalism), pointing

specifically to the ways they have been crafted and utilized with (neo)liberal underpinnings (2006). Indeed, the MDGs (and now SDGs) have become discursive boons for global health and development organizations that can justify their activities with claiming to contribute to the accomplishment particular goals, with no input from the people those goals are ostensibly designed to save.

USAID Gender Policy

USAID's "Gender Equality and Female Empowerment Policy" (GEFEP hereafter) and "Gender Terminology" guide both fall into the model of GAD. In theory, GAD is concerned with integrating context-specific gendered power relations into development activities. This is evident in USAID's policy of "gender mainstreaming," as I will discuss. In practice, however, as the geographer Kavita Datta points out, only women are gendered while men are merely "the problem" (2004), and never, as Dudgeon and Inhorn say "gendered agents" (2003). As the GEFEP demonstrates, the claim to focus on gendered power relations still denies men gender.

Two items stand out in GEFEP. First, there are three photographs on the cover: a woman wearing a hijab is working under the hood of a car, a girl is running across a finish line ahead of a group of boys, and an African man is wearing a baby on his back. All three of these photos are intended to portray the subversion of gender norms that are (assumed to be) dominant in each photographic subject's cultural expectations and changing with the assistance of the all-knowing global health community of experts. This seems to be the current shape of gender as it is represented in development discourse: one that overtly argues for a social constructionist approach to gender and an implication that international development can correct these "backward" constructions. Men and masculinity are not matched in these photos, nor are men's

obstacles or problems. These are photos of project success. This photographic representation still falls under the GAD category, but it signals the possibility of an emergent discourse that speaks to the progress of contemporary development frameworks.

The second major point of interest in the policy is in a breakout box (USAID 2012:3) in which the definition of “female empowerment” is:

[female empowerment] is achieved when women and girls acquire the power to act freely, exercise their rights, and fulfill their potential as full and equal members of society. While empowerment often comes from within, and individuals empower themselves, cultures, societies, and institutions create conditions that facilitate or undermine the possibilities for empowerment” (USAID: Gender Equality and Female Empowerment Policy, Box 1).

This impressive definition does three things. First, it divorces the pursuit of empowerment from a neoliberal, individualistic responsibility. It makes clear that no matter how hard one may work in the interest of their own empowerment, there may be obstacles that never allow the goal to come to fruition. Second, it specifically implicates the capacities of “cultures, societies, and institutions” to elevate or oppress women – what I would think of as “patriarchy” – as those forces. Finally, it relieves men from their rhetorical role as obstacle. This kind of reconceptualization of gender-relations permeates the entire policy thereafter. See, for instance, “Gender-Based Violence,” which deliberately brings men into the discussion, not as abusers, but as potential victims (USAID 2012:7).

The policy is laudable and a positive step in the right direction, particularly where USAID acknowledges structural constraints of women’s empowerment and how men can and should be enlisted to help women. The problem arises in that these statements produce a double-

edged sword. The rhetorical subtext of “structural constraints” and of enlisting men’s aid is that men are in control of those constraints and that they need to be educated in order to better understand the power they possess to harm women and vulnerable populations. In this formulation, again, men are not gendered, rather they continue to be problematized as gatekeepers with whom negotiation is the key to success. Strategies of negotiation are further elucidated in USAID’s “Gender Terminology” guide, to which I now turn.

Global health and development initiatives can and do shape gendered practices and expectations where they are deployed. The willingness to do so is transparent in USAID’s 2007 document, titled “Gender Terminology,” in which they characterize development activities (“design, implementation, monitoring, and evaluation”) based on how they interact with local gender norms. This process is called “gender mainstreaming.” From the guide:

- “Gender-Negative” refers to development activities in which gender inequalities (norms, roles, and stereotypes) are reinforced in the process of achieving desired development outcomes.
- “Gender-Neutral” activities are ones in which gender is not considered relevant to the development outcome, but the process and the outcome do not worsen or improve gender norms, roles, and relations.
- “Gender-Sensitive” activities view gender as a means and aim to redress existing gender inequalities and gender norms, roles, and access to resources so that project goals can be reached.

- In “Gender-Positive” activities, the focus remains on development outcomes, but changing gender norms, roles, and access to resources is seen as central to achieving positive development outcomes.
- For “Gender-Transformative” activities, addressing gender issues is viewed as central to both positive development outcomes and transforming unequal gender relations to promote shared power, control of resources, decision making, and support for women’s empowerment.

While none of these terms appear in USAID’s 2012 publication “Gender Equality and Female Empowerment Policy,” simplified versions are found in the Population Reference Bureau’s 2017 “Gender Integration Continuum Training Manual” (funded by USAID and distributed by the International Gender Working Group) and were used throughout the USAID webinar that I attended in 2019 called “Gender-Responsive Approaches to Reproductive, Maternal, Newborn, Child, and Adolescent Health: Achievements and Lessons from USAID’s flagship Maternal and Child Survival Program (MCSP).” Those terms are “Gender Exploitative” (activities that risk taking advantage of gender inequalities), “Gender Accommodating” (activities that “work around” gender inequalities), and “Gender Transformative” (activities that examine and attempt to remedy gender inequalities).

What is not said in the guide, the policy, the manual, or the webinar is who evaluates “gender inequalities (norms, roles, and stereotypes)” and gender “relations” or “access to resources” at the local level or how the characterized relationship between a development activity and gender is assessed. In the USAID’s Environmental Impact Assessment Tool, the question “Will actions have a disproportionate impact on one gender versus another” is posed for

projects on Air, Surface Water Quality and Quantity, Groundwater Quality and Quantity, Waste Management, Land Use, and Climate (and not for projects on Soils, Ecology and Biodiversity, or Extreme Weather Events). Under “Social Impacts,” impact is assumed, as is the gender variation of that impact: “How do impacts vary between gender? Will the activity disproportionately impact one gender versus the other?” Following both versions of the question, possible answers are “Yes, No, Don’t Know,” and a box for “Explanation.” An example of Social Impact is given for the “construction/site preparation”: “Human trafficking, sexually transmitted infections, other social impacts from temporary construction camps.”

USAID’s policy of assessing local gender issues and what should be done about them in the pursuit of project success is straight out of the French Colonial Theory playbook. The *mission civilisatrice* (civilizing mission) was ostensibly a humanitarian development project rooted in notion that it was the moral obligation of the French métropole, as the pinnacle of human achievement, to elevate their “inferiors.” In the late 19th century, the theory and practice of *assimilation* was implemented across the French empire, especially in the form of education (to teach language, philosophy, and French citizenship), biomedicine (with an emphasis on pronatalism and surveillance to grow the workforce and military class), and law. These European institutions sought to entirely eradicate and replace local systems of education, medicine, and law. A different school of thought was that of *association*, which later gained popularity in the early 20th century. Based in the logic of social evolution, associationists believed that Africans and other colonized peoples were beyond saving, but that colonial administrators and policymakers could find ways to exploit “native institutions” as a means to economic development. *Association* was seen as a useful strategy in cases where uprooting local systems was difficult, instead supplementing or hybridizing them, or in some cases not bothering with

them altogether. While *association* eclipsed *assimilation* in practice in the interwar period, the historian G. Wesley Johnson notes (1971) that after World War II, *association* would ultimately end up being but a stage toward *assimilation*.

There are obvious parallels between the “gender mainstreaming” and French Colonial Theory which are tied together by a moral compulsion to provide humanitarian aid despite (or in spite) of local populations and institutions. The ground that draws colonial and development discourses together has already been thoroughly trod in anthropology, particularly by Arturo Escobar in *Encountering Development* (1995). There, he highlights the overlap between colonial and economic development from the 1920s to the 1950s. On the face, both colonial theory and development are philosophies of advancement toward a telos of higher civilization, and the model society is often an ideal version of the colonizer or donor. In either case, as the anthropologist James Ferguson argues in the case of development in *The Anti-Politics Machine*, whether that telos is reached, the “side-effects” of even a “failed” project can produce beneficial outcomes to the state by extending governance over social life.

Following Ferguson (1990:260-1), the USAID Gender Terminology guide is less a list of jargon than it is a roadmap of development reasoning, or what he calls “devthink.” The jargon, Ferguson argues, is reverse engineered from the desired conclusion. Gender mainstreaming is exactly that: beginning with the ideal outcome of the project, and then appraising how local gender issues may help or hinder that process. In some cases, if local gender issues have to be tackled for a project to succeed, then USAID makes doing so part of the project – much like *assimilation*. In other cases, if gender issues can be ignored, they will be – as with *association*.

Conclusion

The tendency to presume or proselytize universals, whether monoliths, practices, or rights, underpins the global health and development industries going back at least to the UN Declaration of Human Rights in 1948. “Universals” and its inverse “relativism” are topics of over a century of rich literature which arguably define American (or Boasian) anthropology that falls beyond the scope of this work. I do want to highlight however that even in 1947, while the DHR was being drafted, the Executive Board of the American Anthropological Association put out a “Statement on Human Rights” which argued that people could only achieve freedom when they live how their society defines freedom. Julian Steward would later remark that the DHR constituted “American ideological imperialism” (1948). Three-quarters of a century later, global health and development discourses continue to carry forth universalizing rhetorics and anthropologists continue to reject them.

If it is true that men adhere to the monolithic representation constructed by what is and what is not said by development and global health discourse – obstacles to health in dire need of education – it would benefit us to understand men’s experiences and perspectives. Men’s experiences are understudied as a direct result of decades of global health and development discourse that have positioned women, with the moral valence of needing to be saved. It can be counter-argued that until 1970, because of the overwhelming authorship of men as well as a discursive consideration of men as the default gender, the vast majority of global health and development studies (and social science literature) was about really about men. This is true to some extent, but it is also true that men were rarely, as Dudgeon and Inhorn remarked, portrayed “as gendered agents.” I do not argue that the authors of these reports nor the organizers of the conferences truly believe that men overwhelmingly conspire to harm their partners or children.

Rather, I would argue that this discourse is useful because it captivates donors, compels urgency, and because it anchors itself to white savior feminism.

The end result of the report and other documents like it is that they may ultimately do more harm to women and children than good by failing to take into account the existing support systems in which men participate, while threatening to import models of care that are ill-suited for local context. And while DHS 64 constructs a narrative of men's ineptitude, it also threatens to divert much needed attention away from larger and more acute structural issues that harm women and children's health: neo-colonial global capitalism, institutional decentralization, and neoliberal health reform of the last thirty years that incentivize medical negligence and hospital nepotism. The report, specifically the analytical design, serves as but a single example of how men's experiences, social roles, and involvement in pregnancy are overlooked, uninterrogated and overdetermined in global health discourse and studies, further justifying this (my) project in the first place.

Some scholars believe that what constrains discursive change is the enduring misconception that "boys will be boys," that rape, war, sexism, domestic violence, aggression, and self-centeredness are natural to men" (Connell 2005:1811). With Ferguson, I would argue that authors of global health and development discourse are simply not interested in understanding the underlying political-economic causes of women's poor health (let alone addressing men's experiences, perspectives, and equally poor health) because, like the World Bank in Lesotho, it would not be a sustainable business plan (Ferguson 1990:70). The implications in the design of DHS 64 betrays the language of the GEFEP.

The confirmation bias of DHS 64 is not a bug, but a feature. To again recall Ferguson, outlining how USAID deliberately obfuscates locally particular forms of prenatal care is not a

conspiracy theory. It is transparent from the way they strategize gender mainstreaming in the Gender Terminology guide and in their Environmental Impact Assessment Tool. The strategy also resonates with what Escobar has to say about interventions of his study: they “show a significant degree of uniformity worldwide; these strategies rely on a relatively undifferentiated and context-independent body of knowledge and expertise; they are part of a relatively standard discursive practice, a sort of ‘devspeak’ and ‘devthink’; at a general level, they priced similar results, particularly in terms of governmentalizing social life” (1995:146).

It may seem absurd to suggest that DHS 64 is a deliberate and calculated artifact of global health propaganda, but when one considers this document in the long historical context of gendered development discourse, it’s difficult to argue otherwise. I am careful, however, to heed anthropologist James Ferguson’s analysis of intentionality, that such programs (or in this case, documents) are singular cogs in a larger, anonymous “machine” through which discourse is channeled (1990:275-7). Where this report may produce and shape notions of gender, other reports and interventions may produce and shape different sectors of social life. While the cogs may not intentionally miss the mark in favor of other favorable outcomes, the “machine” from which they are derived still benefits from outcomes.

It is important to consider how gender issues, inequalities, and power relations are defined and mobilized, and by whom, as I have here. Equally important, however, is who *does not* get to define these things. Short of dismantling the Global Health and Development machines, what would decolonizing these industries look like? What would aid look like if categories like “men’s involvement” and their statistical indicators and metrics, as well as intervention goals and “progress” were defined by the populations they were meant to target?



Chapter 8: Doing Everything “Right”: Men and Mourning

Yalla yalla bey sa tool.
(God is great, cultivate your own land.)
– Wolof proverb

There is a popular claim, according to reproductive health-focused global health scholars, that if only men would become more involved partners in maternal care, women would have better pregnancy outcomes and infants would be more likely to make it to five years old. This chapter is about three men who were involved to an uncharacteristic degree, not only doing everything expected of them as Senegalese men, but even going out of their way in sometimes socially awkward ways to undertake *affaire u jiggeen* (women’s business). And yet, all three pregnancies ended in loss. Sometimes, men can do everything “right,” according to both local and USAID notions of “male involvement” in prenatal care. And yet...

The Senegalese anthropologist Lamine Ndiaye (2009) writes that death and reproduction are intertwined concepts in the Wolof psyche: Death comes for us all, but we find immortality through our children. Whatever one may believe about a corporeal death or the fate of the soul, Ndiaye reflects, what is certain is that we live on in our offspring. We never truly die. Having children is a blessing from God (“God willing”) that confirms for parents and others (family, neighbors) that you’re in His good graces. It also confirms (or rather, does not disconfirm) that a marital relationship is functioning as it should, and in some situations, it confirms a heterosexual relationship. The failure to produce children, as Ndiaye and other scholars have written, can therefore be a social death and it usually absolves men of responsibility whereas women tend to be assumed to be at fault, infertile, or bewitched. What Ndiaye is telling us, effectively, is that it represents a sort of existential death as well.

Here, I present three cases – a miscarriage, a failed *ngente* (naming ceremony), and a body snatcher - and how expectant fathers processed those losses. This is a chapter about death, mourning, and pain. How to connect dots and analyze these issues that doesn't trivialize the experiences of the families who suffered these losses? The common themes that run between these three vignettes include the threat of existential death, blame, but also (and perhaps more emphasized) the *gendered politics* of blame. Because men are the focal point of my research, it would be easy to interpret the way they cast blame through a particularly gendered lens. In one vignette, a man blames his partner, who decided to do the laundry, for their miscarriage. In another, a man blames the midwives for their loss because of their lack of training and professionalism. What concerns me here is not a gendered aspect of blame, but how men blend worldly cause and effect and God's will, and how they are expected to experience loss. In all cases, men have little or no support for their own grieving while they must continue to work and emotionally support their grieving partners.

There is a euphemism in Wolof for the death of a child, *deellu* or "returned." It marks a short period of time that a child has spent in Earthly life, a sort of fleeting visit that was never really meant to be a long stay. Babies are not named until seven days after their birth at the *ngente* (naming ceremony), at which point they, as I am told, "become people." In one particularly horrible case, the child died the morning of their *ngente* before they were officially named. In another case, the baby died in the nursery just hours after his birth on account of "bad lungs." (It later turned out that the baby was not the couples', rather a corpse that had been switched with their living baby who had probably been sold.)

Deellu does not apply to miscarriages, however. *Deellu*, as an idea, emphasizes that the family was never entitled to reproduction in the first place. Anyone could have been *deellu*.

Again and again, research participants, friends, and family demonstrated this when we talked about childless couples. It's horrible when it happens, they would tell me, but that's God's will and we have to trust in Him.

On the other hand, there is a proverb. *Yalla yalla bey sa tool*, literally "God is good, cultivate your land." What it implies, more deeply, is that God works within the confines of the human experience, that there is a back-and-forth between God and humanity constructing frameworks for each other. "Your family can be in good health and ready to work, the rains can come, the market prices for your crop can be high, but if you didn't even plant the seeds, you have no one to blame but yourself," someone told me.

My research assistant Babacar and I had a hard time talking to people about such sad things as death and loss and childlessness. In general, people just don't want to talk about these things, especially if it could bring bad luck to their doorstep. It was hard, too, because even when people claimed to be open to talking about it (we always asked, "Are you comfortable answering some questions about x, y, and z?"), we regularly ran into the black box of "God's will." Early on, Babacar had the clever idea that we should, after a healthy conversation about "God's will" with interviewees, gently remind them *Yalla yalla bey sa tool*. It worked. Fathers of *dellu* children opened up to talk about the events that led up to (or just led to) their losses. And then it became hard for other reasons.

It was (and continues to be) emotionally difficult for me. After every loss, I retreated to my home in Parcelles to mourn for days. The conference paper that this chapter grew from was the first thing I wrote when I got home (I couldn't get it out of my head) and it was the last chapter I wrote (I didn't want to confront it again). It was hard because men's painful experiences in maternity wards had articulated with what I knew about the Senegalese Ministry

of Health (MSAS) and global health discourse more broadly. It was hard because my training had prepared me, damned me to always be thinking about a broader context - social, historical, legal, medical, economic linkages between global flows of capital and a working-class family in Medina – that brought death to their door. I felt something of the tear between *yërmande* – an emotion that combines empathy, heartsickness, and a strong desire to do something – and helplessness that men who were suffering loss had felt. “I think you’re taking this harder than the parents are,” my brother Diouf once told me. Maybe.

“It wasn’t my turn”: Amadou and Mami

Amadou, 21 years old, is a motorcycle mechanic. He lives on-and-off with his 18-year-old girlfriend Mami and her family – an unusual living arrangement in Dakar for sure. Until recently, Mami was in high school but she dropped out because, as she said, it was shameful to be a pregnant *lycéenne* (high school student). The news of her pregnancy hit her father the hardest. He single-handedly raised Mami since his wife left just after Mami was born, so she and her father were very close, but this was a betrayal. First, he called Amadou and threatened him with violence if he ever came around his house again. Amadou got the message. Mami’s father then tried to kick her out of the house but Amadou called on her relatives to intervene, which they did successfully. Amadou and Mami’s father had agreed to a temporary and fragile armistice so that Amadou could fulfill his responsibilities as a provider.

Though Mami says that Amadou spoiled her with attention, care, and gifts, both Amadou and Mami admit that in her first trimester, while they were both terribly naïve and anxious, it was Mami who did the bulk of the emotional labor for herself and Amadou. Amadou worried for her, her health, the baby, and the delicate bond between them and her father. “I worried so much

about my girlfriend and the baby, and I would call her all the time and ask ‘How are you? How is the baby? Is it okay? How do you feel?’ and after a while, Mami started asking me ‘Are you the pregnant one? You ask a lot of questions.’”

Of course, Mami also worried for her future. “I was very disappointed with the results of the pregnancy test because I wanted to finish my studies first *and then* start a family.” When Mami dropped out of school, she says, her grandmother supported her. “School is too difficult anyway,” her grandmother said. This was another injury to her father whose hopes for her future had been dashed by what he considered to be such a ridiculous accident.

For the first two months, Amadou was riddled with anxiety. “Every time I saw my friends, they would ask if I was sick. I always said it was nothing, but that made it so much harder, not being able to say anything. I would come Mami’s house, Mami would ask me ‘What is it that has you like this?’ I would tell her it was nothing, but the stress was just so great.”

Eventually the couple came to accept and even embrace the inevitable. It became normal and familiar and even kind of exciting for the couple. Amadou would later describe it saying that his courage was growing with the fetus. “A lot has changed now. Just the other day, my friends were telling me that I seemed happier, that I was gaining weight again,” Amadou told us. Even in the bleak beginning, Amadou went out of his way to give Mami everything she needed or wanted. He went to every CPN with Mami and even met with the midwife for advice on how best to play the role of the supportive partner and expectant father. The midwife told him he was doing great, not just finding the money to pay for her medical and nutritional needs, but going above and beyond to accompany her to the maternity ward and engage with the midwives. It seemed like everything was going to be okay, but he’d just have to figure out how to mend things with Mami’s father.

One night, in the fourth month of the pregnancy, Amadou received a voicemail from Mami as he was falling asleep. Neither had enough minutes on their phone to call and have a conversation, so they exchanged brief voice messages for a while as Amadou grew more and more sleepy. Mami had a history of sending Amadou messages saying that she didn't feel well in an effort to get Amadou to come over with food, drink, gifts, or just affection, and so on this night when Mami told Amadou that she was in pain, Amadou – exhausted and familiar with this game – passed out.

A few hours later he woke up to the morning call to prayer and found a number of voicemails from Mami's father – Mami was in the hospital because of the abdominal pains she was having. Amadou launched out of bed, scrambled to get dressed, and raced to find them at *Hôpital central*. It turned out that Mami had never gone to bed. She tossed and turned for a little while before asking her father to take her by cab to *Hôpital du sud*, where she had been going for her consultations. There, the midwives told her that they were not equipped to help her – they sent Mami and her father away suggesting they head to *Grand Hôpital*. The midwives there wouldn't touch her, and they too sent Mami and her father away to their final destination, *Hôpital central*. By the time Amadou arrived, Mami had been admitted but they wouldn't allow him to see her. All they would tell him was that she had miscarried. “For ten minutes,” he said, “my body didn't respond. I just didn't understand if I was still going to have a child. I was hoping and praying but I slowly came to realize that this was God's will. It wasn't my turn to become a father.”

A doctor wrote a prescription for Mami's medication and sent Amadou out to get it at the nearby pharmacy. He couldn't read it, but he figured the pharmacist would be able to. “It's completely illegible. Go back and get another one,” the pharmacist told him. Amadou returned to

the hospital, but he couldn't get anyone's attention. He stood outside the *maitresse* midwife's office, knocking every so often while trying to flag down junior midwives in the hallway.

"They're all on WhatsApp or talking on their phones when they walk from one room to another and they won't even look up and acknowledge you!" Amadou eventually got a new prescription and got it filled. He paced the sidewalk in front of the hospital and sat on the steps, he bought coffee from the *pousse-pousse* (coffee vendor's cart). He wouldn't get to see Mami until noon.

When Amadou was finally able to see her, he says he felt *yemandé* – a Wolof term that combines feeling pity and compassion, but emphasizes a strong desire to act in someone else's care or interest. "I told her I didn't want her to cry, because it was God who gave us this pregnancy and maybe it would be a good thing for us." Besides, he thought, given of all of the work and anxiety he had put into caring for her and the pregnancy, if anyone was entitled to cry for this loss, it was him – but crying doesn't solve anything. "We came back home and she wanted to continue the same thing she was doing at the hospital – crying – and I told her that that wouldn't solve the problem and to have faith in God. I left to buy us some things and came back to soothe her and talk with her, but it hurt me more than it hurt her."

"Doctors need to give more consideration to their patients. Even if there are only two words they can share with their patient, that would soothe them," Amadou explained to me. The most they can muster, he says (and I have witnessed), is "Go wait over there." Amadou remembers getting so frustrated that people were telling him to lay off the midwives. "Lay off! The midwives are stressed out too!" someone told him. "If I wasn't in control, I would have fought someone," he tells me. Amadou, of course, isn't suggesting that the way they were treated in hospitals - at this point or any other point - led to a miscarriage. What this demonstrates is just one of the ways that Amadou directs his frustration, because he can't be mad at God.

Days after the miscarriage, Mami had a confession: She did the laundry the day of the miscarriage. Hand-washing laundry is not an easy job. It's exhausting labor on the back, wrists, and hands. Normally, Mami was under the watchful eye of Amadou, or her aunt if he wasn't around, and normally she had to be reminded not bend over, but this time, no one was there. The laundry needed to be done. She cried as she admitted everything and Amadou took that as an opportunity to make sure she knew that she was solely to blame for the miscarriage. Amadou was upset because he knew she knew better — they read the *carnet* together and it specifically says that pregnant women should avoid heavy labor and bending over. But he eventually relented: "It's God who gave this to us and took it away. We just have to believe in him."

Amadou managed to mend things with her family, who praised him for his excellent post-recovery care of Mami. Her parents consoled him, "Just believe in God." After the loss, he continued doing many of the same things that he was doing while she was pregnant: earning money, paying for prescriptions, reminding her about and escorting her to her doctor's appointments, and watching her nutrition and physical activity. He tells me, "From the beginning, her father and brother and I were fighting ... but her family eventually warmed up to me after the miscarriage because they saw how well I was taking care of her."

Months later, Amadou tells me that while this was a painful experience for him and Mami, they now know that the good was not immediately apparent to them. Not only is Amadou's relationship to Mami's family stronger than ever before, they can both confirm that they're fertile, which is a major concern to young Senegalese as they approach a more reasonable age of starting a family. Today, Amadou and Mami look forward to slowing things down and taking advantage of their second chance to finish school and find financial stability. "All the stress has left my mind. Right now, I just pray that we can have another."

Amadou and Mami found a sort of bittersweetness in their situation. While Amadou was acutely aware of the unfriendly atmosphere of the maternity ward, he and Mami were much more willing to move on and be grateful for a second chance. It was not only God's will that the pregnancy should be terminated, but it was God's will that their chances at being well-prepared, educated, and married before parenthood should not be impaired.

Is it really me who has had this child?: Mansour and Fatou

Mansour is 27 years old and he works for his uncle's halieutics export business during the day and sells perfumes and colognes as a side job. Fatou is 19 years old and worked for a short time during and after high school as a seamstress. She wants to pursue a career in fashion. Mansour and Fatou were married in the spring of 2017, one year prior to my meeting them, and Fatou was pregnant by the end of that year. She quit her last job before becoming pregnant and hasn't sought a new job because her family didn't believe she should work while she was pregnant.

Mansour and Fatou were both very excited for the pregnancy, impatient even. There was about a six-month gap between being married and the beginning of the pregnancy, which was too long as far as they were concerned. "We know people who got married after us and they already have their kids now," Mansour told me when Fatou was in her second trimester. "All the time, I was watching her cycle," he says, "and she would tell me, 'You also need to make sure that everything is okay in your own house' and I would say, 'I don't have any problems! I only believe in Serigne Touba (another name for Cheikh Amadou Bamba, the founder of the Mouride Brotherhood), so you just keep going to the hospital if you think there is something [a pregnancy].'"

Not long after, Fatou became sick. She told Mansour that she has abdominal pains and that her body was very warm. They went together to the hospital where she was examined, but they told her that they didn't find anything. As they left, Fatou was prescribed a medication that made her vomit all the time. On the way home, Mansour bought a pregnancy test just to check. At home, Fatou took the test. "I was crying," Fatou told us, "because I was believing that I was sick but he told me that I could be pregnant. I didn't want to believe it until I saw the two bars on the test. It was a surprise! The emotion of having a child was rather strong that he also started crying and said a prayer for me. After, he said he would talk about it to no one until he found me some protection against evil eyes and tongues. I was about 3 months [pregnant] when he told his mother. She told him to tell me to pay close attention and avoid lots of things."

From the beginning, Mansour was deeply committed to Fatou's prenatal care, emotionally, financially, and spiritually, but he also wanted to learn as much as he could about pregnancy so that he could monitor her health. "From my point of view," Mansour tells me, "I have to have *yermandé*, I have to watch [Fatou's] health." Even though Fatou, like many Senegalese women, has an entourage of supportive and more experienced women around her, Mansour says, invoking a Wolof saying, "She has a foot on the earth and the other in the world of the dead. I have to master the situation as she progresses." Mansour sought out a *gris-gris* (talisman) for Fatou to wear which will ward off the effects of the evil eye and evil tongue. (Fatou doesn't actually like wearing the *gris-gris*, stating "I don't believe in that. It's God who decides to give a child or not." She wears it sometimes to appease Mansour and her mother-in-law.) The surveillance includes making sure she's taking her iron supplements and vitamins, making sure that she's eating the right amount of the right kinds of food at the right times of the day, reminding her what kinds of foods or behaviors to avoid or increase, making sure she dresses

properly, and of course reminding her to go to her prenatal appointments and then checking her *carnet* to make sure that she actually went. “He reads the *carnet* all the time,” Fatou adds.

Mansour nods.

Upon confirming the pregnancy with the midwife, she was told, “You have to stop your too-free behavior (*comportement trop libre*, referring to things like engaging in nightlife). You’re not alone anymore, so you can’t behave like an adolescent who has nothing to care about.” Mansour, who was present for the conversation, considered this a conscription. Fatou would no longer eat oily foods at night or bananas at any time of the day, because Mansour forbade it. Fatou’s mother advised her to avoid people - no weddings or other celebrations - and Mansour enforced the rule. “I don’t really talk to others. I don’t want them to discover [the pregnancy] because there are people who can wish that you don’t have children, so I don’t talk about it to other people in order to protect myself,” she says. Pregnant women are regularly advised by midwives, mothers-in-law, and the state (i.e. the *carnet*) to strike a balance between staying active and avoiding work. There too, Mansour makes sure she’s only doing what she can manage, while taking up some domestic labor for her and taking her out for night walks (*ndoxantu*). “Look at how this bedroom is so clean and well-made!” she gestures. “It was he who did that this morning!”

Mansour tells me that the most crucial way one can support their pregnant wife emotionally is to reassure her - verbally and physically - that she is not alone. When Fatou is worried or anxious about her health or the health of her unborn child or their future, she tells Mansour, who in turn tells her that everything is going to be okay. “He cuddles me, he teases me, he does everything to avoid annoying me, and sometimes my mood makes it so that I do nothing and that makes him come and try to make me smile and sometimes that makes me angry, so it’s sticky. Sometimes, when I really want to eat something that is forbidden, he tells me I can’t eat it and

insists, but I know that if I insist more, he's going to give in and buy me some or let me eat some, because he doesn't want anything to displease me or hurt me, much less make me sad." Sometimes, her anxiety is contagious and he begins to worry too. In those cases, he defers her to experienced women - their mothers or her girlfriend who lives nearby with her husband and child. She tells Fatou, "That happens like that," or "That's not a big deal," or "Don't worry about that, it's normal." "If I know that my husband doesn't master some things, I'll first ask my girlfriend. I'll go talk to her about it first as not to worry him."

One day in September, about a week before the due date, Fatou started to have very sharp pains. This wasn't a normal kind of sporadic, passing, abdominal discomfort – this was intense and persistent. Mansour had learned from the midwife that he could tell that labor begins when these pains begin and she's bleeding a pinkish blood. He checked between her legs, and sure enough, there it was. "There's no time to lose!" he said, and he hailed a taxi to the nearby clinic.

When they arrived, he bought a consultation ticket for her and they waited patiently in the waiting room. The first thing the midwife did when she brought Fatou into the consultation room was a sonogram. "The baby is sideways," the nurse said. "We need to wait, otherwise you won't be able to give birth normally" (*accoucher normalement*). She wasn't confident in the clinic's ability to assist in case of an abnormal birth, so they suggested Mansour take Fatou to *Hôpital Central* or *Grand Hôpital*, but Mansour didn't want to go to *Grand Hôpital* because they knew it would be too crowded. When they got to *Hopital Central*, they bought another consultation ticket, and went to the maternity ward, only to find it empty, save for the housekeepers. Mansour's mother is a housekeeper who gets up to start work every day at 5:00 AM, so in his mind, there was no excuse for the ward being closed for cleaning by the time he had arrived after 8:00 AM. They took another taxi to *Grand Hopital* – where he didn't want to go – bought a third

consultation ticket, and were told by the midwives there that there was nothing they could do to help Fatou's situation except for wait it out. They advised Mansour and Fatou to return to *Hôpital Central*. They prescribed some pain relievers for Fatou who went back to *Hôpital Central* with Mansour's mother while Mansour detoured to the pharmacy to fill the prescription and run home to pick up some more cash. Fatou and her mother-in-law arrived at *Hôpital Central* where the ward had previously been closed for cleaning, bought a fourth consultation ticket, and found the waiting room absolutely bustling.

They were deflated. Fatou would have waited hours to be seen were it not for a distant aunt, who cooks in the small restaurant in the hospital. The aunt saw her and her mother and asked what was going on. After they told her about being bounced from hospital to hospital, spending all this money on tickets and taxis, all while in so much pain, the aunt stood up, walked in the ward, and cornered a midwife. "I cook for you every day! I satisfy you and then you don't help me? That's my niece! I want you to help her!" The midwives relented and took Fatou into the delivery room. The baby was born by cesarean at 5:45pm.

Mansour, who had left to fill the prescription and run home for cash, was walking out of his house when he got a call from his mother. He knew, before she even said a word, what she would say. "It was like a sixth sense. I started to smile. I asked her 'Is it really me who has had this child? I can't believe it. Is it really me?'" Mansour knew people who had children before marriage, and he knew people who'd been married a long time without having children. That he could get married and then have a child so soon after the wedding was a truly divine blessing. His prayers had been answered. Mansour hailed a taxi and met his wife and newborn at *Hôpital Central*. They were well and it was a boy. *Alhamdoulillah*.

Five days later, Mansour was walking me into the small bedroom that he and Fatou and the tiny baby boy were occupying in the family compound. Fatou was lounging on the mattress on the floor with two of her friends and the baby asleep. I was given the cushy armchair and a glass of pineapple juice. Mansour sat on the floor with his legs crossed. Everyone cooled themselves with woven plastic fans, but they pointed the electric oscillating fan at me. We exchanged salutations and other pleasantries – Fatou looked exhausted and Mansour couldn't stop smiling from ear-to-ear. He was beside himself. I asked if he'd had a chance to hold his son yet - not a particularly common practice among older generations, but Mansour was younger than me. "The day before yesterday! It was a little difficult at first, but I can't even tell you what I felt!" As Mansour proceeded to retell the intense birth story, his grandfather dropped in to offer his blessings on the new family (and on my research). When I mentioned that I had been in the neighborhood and I called Mansour to see how he was (not knowing about the birth before I called), his grandfather reminded me, "You must know, there are no accidents."

Before leaving, I was invited to the *ngente*, the naming ceremony which always takes place seven days after the birth of a child. I love *ngentes*. "Only if there will be *laax*," I said, signaling that I'm no stranger to the event. Everyone laughed. "We'll see you Wednesday, *inshallah*," they said.

God willing.

The following night, Mansour was jarred awake by his six-day-old's high-pitched wailing. Mansour and Fatou tried to get him back to sleep, but he just wouldn't stop crying. Mansour let Fatou get some rest and he took the baby to a masseuse in the neighborhood where the baby's abdomen began to swell. He went quickly to the clinic where they wrote him a prescription.

In hindsight, Mansour tells me, “Those bastards should have told me to go to the maternity ward.” He filled the prescription, gave the baby the medication (I didn’t ask what it was), and the crying and swelling continued. Back at home, he left the baby with his mother and brother and went to find the masseuse again, but she was gone. He sought another one further down the road, but she was gone too. He went to a *marabout* for a *gris-gris* (a sort of magical charm or spiritual medicine) and upon returning home learned that his mother and brother had taken the baby to *Hôpital Central* where the baby was born. His wife’s aunt – the woman who agitated for her to be prioritized by the midwives when she was in labor – was there to advocate for the baby to be admitted to the ER. All Mansour can tell me after that point is that the doctors sucked something from his son’s stomach, but the kid was dead by 3:17 AM. His mother called to let him know what had happened. He sobbed quietly, letting his wife sleep, and taking the time to think of how to tell her. By 6:00 AM, after the morning prayer, he and her uncle broke the news to her.

Three hours later, I was walking down his street with Babacar. We could see the large tent that would shelter the hundred or more guests from the blazing heat of Sahel sun blocking the street in both directions, but we saw no one. *That’s okay*, I thought. *I’m early to everything*. When we arrived at front gate of the compound, Mansour’s uncle was there, but the courtyard was empty. “There will be no *ngente* today,” he told us. All he could tell us was that the baby had died, nothing more. We were in shock. We’d just seen them. How could this be? Dressed in our most extravagant attire, we silently made our way back to the main road. We sat on the curb sobbing, smoking, cursing. “That’s so fucked up, but we have to trust God,” Babacar told me. All I could think of was the way Mansour and Fatou had been treated in the hospitals.

We mustered the strength to call Mansour and offer our condolences, but we did not pry for the details. He was on his way to the cemetery to bury his son. We did not attend, and thankfully

we were not invited. It wouldn't have felt right to me. When Mansour returned home, he was obligated to kill the ram as if the *ngente* had continued because, uncharacteristically, they had quietly named the baby in advance of the ceremony. Dying with a name, he explained, means that that baby was someone, and sacrificing the ram ensured that he would leave in peace.

Six weeks later, Mansour, Babacar, and I were ready to talk about what had happened. Mansour recounted the story as best he could. "I did everything spiritually so that my wife wouldn't have to give birth by cesarean, but she did anyway. I even had the marabout pray into a bottle of water which she drank... And we did everything the midwives and the doctors and the *carnet* told us to," he told me, reaffirming all the ways he and Fatou had described how he looked after her. "Losing a baby is the will of God," Fatou told us months before, "either because they weren't protected or they didn't follow their CPNs to the letter."

"This is just what I get for my behavior," he reasoned, referring to his troubled youth which I don't really know much about, aside from the fact that he and his relatives talk about him as if he's "born again," in a way. "I know I wasn't always a good boy, but that child was born into a marriage and he was someone."

Weeks later, Mansour had gone to Touba for Magal - a great pilgrimage of millions of Mourides to the holy city about three hours away from Dakar. "That saved me," he says. "Otherwise, I just would've stayed here and that would've been the worst." He describes how he took his problems to Serigne Touba and finds a sort of calm in the storm of life, a renewal.

We asked about Fatou, who was still reluctant to come out of her bedroom. Fatou was in a bad place. Her older brother had just had a child. Mansour and Fatou went to the *ngente* but it was difficult. There, Fatou was talking with the new mother, her sister-in-law, and said she should bring the baby over to their house so Fatou could wash it. The mother laughed, "Do you

even know how to wash a baby?” before catching herself - she’d forgotten Fatou had a baby for a fleeting moment. “I found her in our room later that night just crying. She’s always thinking about him when she’s alone. That’s why when I leave for work, I tell her to go to her mother’s house. I need to buy her a television or find her a job to keep her busy.”

“It’s been so hard for me,” Mansour tells me, “but it’s so much harder for her. She was pregnant for nine months, and went through all that pain. With all that she endured, I hate myself for being upset. She is such a brave woman” (*brave dame*).\

Bad Lungs: Moussa and Binta

When we met Moussa and Binta, they were living together with Moussa’s mother’s family and expecting their first child after having been married for four months. Moussa works as a coppersmith and a contractor. His father lives a few neighborhoods away.

Binta and Moussa both grew up in Medina and have lived in Dakar their whole lives, “except for one time I went to Gambia,” Binta says proudly. They’ve known each other since they were children and went to the same schools. Moussa finished high school and the *baccalaureat*, but never proceeded to university. Binta is quite proud of having studied government bureaucracy in high school, but like many Dakarois women, never finished. Instead, she left to find work to help the family. Until she became pregnant, she’d been a housekeeper at one of the nearby embassies, but the contract ended shortly after she and Moussa were married, and the embassy did not renew it. They decided they’d rather conceive anyway.

Moussa was thrilled at the idea of being a father. When they began trying, Moussa says, he was regularly monitoring Binta’s menstrual cycle. Binta suspected she was pregnant when she’d missed her period for about a month and a half. She and Moussa went to the hospital to get

a test, where he asked many questions, he says, “because I want to know everything!” Binta recalls that she didn’t really need the test to know, but that was just to confirm it for Moussa. “A married woman who consummated the marriage, who is not protected against pregnancy, who has sex with her husband normally gets pregnant - so yeah, I knew. Four days late? I get that. One month and sixteen days? That’s another thing.” I wondered how closely Moussa could’ve been monitoring things if she’d missed her period for 46 days before they decided to get a test.

The test, of course, came back positive. The couple was ecstatic. “I was very happy, like all women are!” Binta says. “If a woman is married and gets pregnant, she’s is thrilled!” On receiving the good news, Moussa “jumped for joy,” he says, and said a prayer to thank Allah and ask for good health for his wife and child. After that, they told no one, not until the second trimester when they told their mothers.

Binta’s home life with Moussa’s parents, she says, “is...hmm...fine. We’re good.” I’m not convinced. “We’re as any parent and child.” Normally, she wakes up around 10:00 AM, sometimes earlier, to do chores. (This is later than most people, but her pregnancy gives her some leeway.) “As you know,” she says to my research assistant Fatimata, “when you’re the daughter-in-law, it’s you who has to do all the chores in the house. I’m the only daughter-in-law.” Binta works every day from Monday through Sunday, cleaning the house, cooking the meals, doing the dishes, and preparing dinner. The family rents out a room to two students - a common practice in Medina which is so close to the university - and they do the domestic work on Sundays.

Moussa, like many other men, was profoundly invested in monitoring his wife’s health throughout the pregnancy. He makes sure she’s going to her CPNs, that she’s eating right, avoiding too much work, and staying out of sight. Binta appreciates the care. He cooks, he

cleans, and he helps her with other domestic labor where he can. “My husband really takes good care of me. He’s very kind and attentive. He worries and helps me learn and know things I need to do. He gives me gifts.” Other people in the household, she says, don’t really understand why he’s so invested in the pregnancy. It’s strange that he would want to learn about pregnancy or monitor her activities. Because of his efforts though, Binta says Moussa understands her better than most. “Those other people in the house aren’t super-understanding.” She feels blessed to have Moussa in her life. “Some men start seeing other women when their wives get pregnant, but others change in positive ways. Moussa has become more loving and attentive.” There is little, if anything, that he can do to displease her. She loves when he calls her from work to check on her, to see how she is, and to see if she needs him to pick anything up for her on the way home. “He worries about me and it makes me feel good to know he’s thinking about me, even if I’m in a bad mood.” It’s important to the both of them that Moussa remains a (financially and emotionally) stable feature throughout the pregnancy. He does get frustrated with Binta or anxious about the pregnancy sometimes, but he’s always careful not to show it. “I leave, I cry, I frown, but I don’t hit and I don’t show her my feelings.” It seems to show in her interviews that she has no idea.

Tabaski (also known as *Eid al-Adha* or The Festival of the Sacrifice) is arguably the most important, celebrated holiday in Senegal. Money, fine goods, and healthy rams are socked away for weeks or even months in advance in anticipation of the feast. It is an intense period of reinforcing family bonds and for many men, that means performing social and economic stability, if not power and wealth. *Tabaski* is one of the two or three major holidays of the year when Dakar turns into a ghost town as rural migrants, Muslim West African expatriates, and

first- or second-generation Dakarois - a vast share of the population - return home to celebrate and deliver gifts. Following *Tabaski*, there is a slow return to the city, to normal life, and it can take weeks.

This year, *Tabaski* fell on a Tuesday/Wednesday. That Friday night, Binta felt sharp pains and they were progressively getting worse. Normally, Moussa helped Binta get through the discomfort, but this was intense and unfamiliar, and there was nothing he could do. She was scared. When they got to *Grand hopital*, the waiting room was packed, but Moussa was distressed to find there were almost no personnel, save for a physician and a few *very young* midwives. Worse, they learned that they had arrived just as a new shift was beginning - no more personnel would be arriving until the next shift change on Sunday morning. They were given a prescription for the pain and told to come back then.

In hindsight, Moussa says she could've just given birth that night if they'd started the process. She was ready! Or they would've gone to another hospital, as so many do, but they weren't told to. "We just wanted to follow the advice of the doctor and the midwife. I told my mother about it and she just said, 'Listen to the doctor.'" He'd done his homework on the place, that's why they chose *Grand Hopital*. "They had highly experienced midwives. You know, they even moonlight at private hospitals!" he told me. Weeks later, Binta told Moussa that she had seen women being ignored or verbally mistreated that night. "If you'd told me that, I would've never returned there," he told her. "We should've gone to *Hopital central*," he reflected, "but it was too far."

The medication made the pain even worse. Saturday was unbearable, but nothing could be done if they weren't willing to try another hospital. Moussa stayed with Binta all day, soothing and massaging her, driven by a fierce sense of *yërmande* but ultimately feeling helpless.

Sunday morning, when they returned to *Grand Hôpital*, they found that the situation had not improved. A new shift of personnel had taken over, but they were still very few and distressingly young. “A woman’s first pregnancy is very risky,” Moussa worried, wishing that someone more experienced had been there. Worse yet, there were women in the waiting room who were still there since Friday night. Two hours later, Binta would give birth before they would. The delivery, by all accounts, went smoothly and without incident: The baby girl cried. The umbilical cord was cut. Binta held her newborn for a short moment, and a midwife whisked the baby away to the nursery.

Meanwhile, Moussa paced the long corridor outside of the delivery room and the recovery room and the waiting room; he paced into the courtyard and sat on a bench and stood up and walked and walked and walked with nauseating anxiety of not knowing anything, of leaving his wife and child in the hands of young women who, themselves, had probably not given birth. He went back in to find a nurse and see what was going on. Binta had given birth and the baby was fine, but that’s all they’d say. “They don’t tell you if it’s a boy or girl, they just say it’s in the nursery, but they wouldn’t even let me go see it because I’m a man.” They wouldn’t even talk to Binta “but it’s *Grand hospital*, so I guess that’s normal,” Moussa says, speculating about the high ratio of patients to providers.

Binta laid on the bed in the recovery room surrounded by Moussa and his parents. She was exhausted. She slept. She ate. Hours passed. She asked to see her baby, but the nurses wouldn’t allow it. Moussa, torn between distrust in the young midwives and trust in the medical authority, progressively became more upset by how he and his wife were being treated.

He snapped and cornered the physician on duty, demanding to see his child. The physician, annoyed, pulled Moussa aside to tell him their baby had died. She reviewed the *carnet*

and found that everything had been normal throughout the pregnancy - if they had anticipated a problem, they would have caught it. This was just a case of “bad lungs” (*les mauvais poumons*). They were not sufficient to keep the baby alive, she said. “It’s not a big deal. You’re young, you can have others,” the physician advised. “How could I respond to that?” Moussa asked me indignantly.

Moussa broke the news to his family while the baby was taken to the morgue. He sat with them while they alternated between shock, disbelief, and prayer. “I told Binta just to have faith in God. I told her it could’ve been her who died and that if I had the choice I would’ve chosen to keep her because she’s everything to me.”

The baby would need to be buried by the end of the day, in accordance with Islamic funerary custom, but the administrative paperwork and “certain formalities” in the morgue delayed the burial to the next day. Monday morning, Moussa went to the morgue to collect the remains. There, he found the boy’s body had been washed. He said a prayer for his child, but then he thought of something. Moussa could have sworn Binta said she gave birth to a girl. Maybe he was misremembering. Maybe shock and anxiety was messing with him. He received the boy and interred him that afternoon. Still, Moussa had to double-check with Binta. “Did you say we had a girl?” She insisted it was a girl. His mother and her sister later confirmed they saw a girl in the delivery room. He wasn’t mistaken, he really did have a daughter! But if that wasn’t her in the grave, where was she?

The next day, Moussa returned to the morgue to question the men whose job it is to clean and purify the bodies. “They gave us a boy. The paperwork had your name on it,” Moussa recalled the morgue worker stating. “You should file a complaint. In all my time here, I’ve never seen this happen,” one of the men working at the morgue advised Moussa. He didn’t want to,

though. Binta was on his mind now and he worried that filing a complaint would prolong her suffering. His parents wanted to file a complaint, but he convinced them not to. The doctors will just protect the midwives, the administrators will protect the doctors, and the Ministry will protect the hospital. No one wants this to get out. It would be a scandal. Moussa is again torn between *yemande* and helplessness. “The past is the past. I’m not going to get hung up on something that’s not possible.” Months later, Moussa heard about another couple who had received the wrong baby in the morgue at *Grand Hopital*, just two weeks after their ordeal. “The man filed a complaint, and nothing happened. See? I told you,” he explained to me.

“It’s God will that this happened, but it’s happened because of the midwives,” Moussa would later tell me. If the midwives aren’t doing their jobs, then everything depends on God, but they have to do their part. He’ll never consider going back to *Grand Hopital*. Moussa won’t - and shouldn’t - accept that an otherwise “normal, health pregnancy,” in his words, ended this way. He even suspects a systemic plot against African population growth. “That’s what hurts so much. We wanted for nothing. My wife went to all of her prenatal visits, and every time she left the house, I gave her money, and if they gave her a prescription, I took care of it.” Moussa says he’ll never go back to *Grand Hopital*, and isn’t particularly interested in returning to a hospital ever again. Not long after the kidnapping, a friend of Moussa’s went to *Grand Hopital* with symptoms of some illness (I didn’t ask), received a shot of something (again, I didn’t ask), and ended up paralyzed. “I won’t even take prescriptions or give them to Binta until I check with my uncle who is a pharmacist to make sure they are the right thing.”

Everything about the experience in the hospital set Moussa off. “You can’t even tell the difference between the midwives and the housekeepers until they come at you with a syringe,” he recalls. “And the way they tore her up was just awful. The way they opened up her vagina [an

episiotomy], the stitches took at least a month to heal.” As is standard practice, at least among many of the women I worked with, Binta was put on birth control following the delivery. “I still don’t trust them,” Moussa says about the hospital and the pills. “What if that creates complications tomorrow?”

To quote Moussa at length,

The doctors must help people during birth. It’s a question of life and we have to respect it. In a country where healthcare doesn’t work and education doesn’t either and there are no jobs, what is going to work? Nothing! Normally, we should have the power to advance and in Africa it’s time that we advance and stop waiting for anyone else. The doctors have to know that, otherwise there will be more lives lost. You could be a very experienced and well-trained midwife, then it’s your job to teach people to do it for love and not money... [I’ve been conscious of these issues] since I was very young. I went to the hospital one time because malaria was [kicking my ass] and I needed an IV – otherwise, I was just staying inside and suffering. My mother told me to go to the hospital and I kept saying no. When I finally went, there was an old diabetic man who had been given a glucose drip and he died. This is why I don’t trust them; the doctors are all distracted, they don’t take the time to reflect on their patients, and when you go there, what you see is midwives and nurses on their phones... That was the first time I’d ever gone to a hospital and that old man came, they gave him the drip, and he died that night in front of my eyes. Why wouldn’t they test him for diabetes first? ... You see my baby is dead. If I wanted, I wasn’t even going to pay the hospital bills because I could’ve said, “They didn’t take care of my case and now the baby is dead.”

We ask about Binta's recovery. Moussa responds, "She's empty now. Nine months is a long time to dream, only to have your baby die." Binta hasn't left the house, even six weeks later when we last spoke with Moussa. "She might go into the courtyard, but that's it." He thinks she's getting better now, but she's still having a hard time. "If there's a pregnant woman on television, she changes the channel." He continues to try to soothe her and let her know that God is looking out for them.

"The kids in our neighborhood were all telling her that they wanted to throw a birthday party and that she would have to buy gifts, and I just cried because I didn't know how to tell them..." Moussa trails off. "She prepared all of the clothes and things for the baby. I had already bought the ram for the *ngente*, I had a beautiful boubou tailored. People even told me not to do any of that until after the birth, but I did because I don't really buy into that stuff." Six weeks after their loss, when we last saw Moussa, the ram was still on the roof.

Conclusion

In this chapter, I have described three radically different types and experiences of loss. In each case, men and their families were quick to refer to "God's will" – an unquestionable black box of fate, as if to say, "That's just the way it is." But, it's also clear that God's will works through people – the cultivate their own land. In a way, while "God's will" and cultivation are blended methods of explanation and healing, they are answers to different questions – "why" and "how" respectively.

In the end, it's unremarkable that men would blend worldly cause and effect with God's will as a way of reasoning through their experience and moving forward. It's not a particularly

gendered practice to do so. What is noteworthy, however, is the gendered expectation of mourning. In all cases, it is completely acceptable for women to hide away in their homes and grieve, sometimes for up to 40 days. Men, on the other hand, as heads-of-the-household are expected to be disappointed or angry, but also be able to move on relatively quickly. Men must continue to work, to “find the money.” There is little tolerance – from an employer, a doctor, or the economy – for taking time between a loss and getting back to work (not that they ever left work in the first place). Additionally, with the social expectation of being more emotionally mature, men must also console their mourning partners. There appears to be little support for the men in these cases, with the exception of Mansour who found great relief during the *Magal* to Touba.

Another remarkable theme is in how the men talk about their experiences in hospitals and with hospital personnel, a topic to which I will return in the concluding chapter.



Chapter 9: Conclusion

Lu metti yàggul te ku muñ muuñ.
(Pain does not last, whoever perseveres smiles.)

- Wolof Proverb

Near the end of my research period in December 2018, I had to escape the cold cement block house Diouf and I had built, the office space I had made, the deaths that were fresh in my memory, and the imminent U.S. holidays that I would spend alone. One of my hideouts was a small restaurant on the northern tip of the peninsula in *Les Almadies*. It was a tourist trap and I would have to dodge vendors on the walk from the taxi down to the shoreline where the tables and chairs were (*Jerijef, baax naa* [Thanks, I'm good]), but the fresh seafood and sunset view were worth it. This night, I met two colleagues for dinner: Marlee Tichenor, a U.S. anthropologist, and our mutual friend Mohamed Ly, the former *medecin-chef* of *Hopital Sud*.

Ly is an infamous figure in the Senegalese government but specifically at MSAS. He's a remarkably outspoken radical syndicalist and a 40-year member of the Senegalese Communist Party. He proudly regales me with stories of his time studying medicine in East Berlin. I'd known Ly since at least 2015 when, somehow, he'd found me on Facebook. Then, he asked what my business was in Senegal and I told him about my interest in expectant fathers. He invited me to visit him at *Hopital Sud*, where he worked at the time, and discuss the matter with him and so I did. Ly loved the idea that we should examine how men and others support pregnant women, that research on reproductive health should take families and communities as the focus, rather than individual pregnant bodies. His generous feedback shaped how this project fit into a broader narrative about global health and state healthcare. It was he who helped me develop the methodological strategy of speaking with pregnant women first and then their partners. In the end, he offered his own maternity ward as a research site, as soon as I had clearance from CNRS

at MSAS. By the time I had clearance and was able to start research in the wards two-and-a-half years later, he had left *Hopital Sud*, or rather he was moved. Ly had a propensity for organizing and leading healthcare worker strikes (a relatively frequent occurrence in Dakar), writing cutting criticisms of the healthcare system on his blog, and speaking out on public radio. MSAS stuck him in an office.

That night, I explained to my colleagues that I was profoundly affected by the losses and deaths - perhaps more so than the families themselves, as Diouf had suggested. I expressed a sort of naive anger about the midwives, based on what I had seen of them in the waiting room and on what I had heard so many men tell me - they're negligent, they're always on their phones, they're always texting, they're always locking themselves in their offices, they're always ignoring you, "they never tell me anything, because I am a man." I told them about how literally all of the women we followed up with (except Binta) had been turned away again and again *while in labor* from hospitals because they were overcrowded, or under-resourced, or closed for cleaning, or how once they found a hospital to serve them, they would wait hours because other patients could afford to buy their ways to the front of the line. I relayed what Moussa and the *maitresse*-midwives had told me about the women who work "for money, not for love." I was distressed and depressed and pounding glasses of wine while they watched me fall apart.

Ly finally intervened. "Dick, you're an anthropologist. You know better than to blame the people. There are structures of the state that teach and encourage people to be this way. They don't know better. They're just doing what they can to survive too." *Snap out of it!* Ly seemed to say. And I did. But I'll come back to that.

The Arguments

Here, I have tried to present three interlocking arguments about prenatal care and carefulness in Dakar. First and fundamentally, I have argued and demonstrated that due to expectations of kinship and gender, expectant fathers play a small but profound role in the system of prenatal care. The broader system, called the *entourage* (French: “those who surround”), is a team effort of close female relatives who support pregnant women in different ways, usually by taking up domestic labor and providing emotional support. Men are expected, above all, to bankroll the material needs of a pregnancy - medications, consultation tickets, taxi fares, hospital stays, and the ram, among other things.

Second, I have argued that through a variety of media rhetorics, particularly of the state-authored *carnet* and *Bajenu Gox*, the state disciplines pregnant women into pregnant *subjects* who strive to maintain their health by following prescribed behaviors and rational decision-making. By extension, in a process of rhetorical *anti*-articulation, men’s belief that pregnancy is *affaire u jiggeen* (women’s business) is reinforced, thereby enlisting them as enforcers of state rhetorics enacted through surveillance (related to the French *veiller*, “to watch after”). They demonstrate both “care” and “masculinity,” not just with financial support, but by showing concern and *yermande*, and their pregnant partners have confirmed that these practices do in fact make them feel *cared for*.

Finally, I have argued that global health scholarship and organizations - USAID in particular - have based their interventions on false assumptions about what prenatal care “should” look like. In the case of USAID and their report “Does Men’s Involvement Improve the Health Outcomes of their Partners and Children?” I argue that the statistical indicators are arbitrarily determined from Euro-American models of masculinity and prenatal care. This formulation risks misdirecting healthcare funding and interventions toward a problem that

doesn't exist, which in turn puts the lives of women and children at risk by effectively doing nothing about the problems they *do* face. Even more insidiously, it's easy to interpret the report as propaganda which serves to keep organizations like USAID in business, because solving the greater problem of maternal and infant mortality would render those organizations (or at least branches of those organizations) obsolete.

Global Importance

This work makes a critical intervention into conversations in anthropology and global health at the intersections of gender (and masculinity more specifically) and reproductive health (or pregnancy, labor, and delivery). It can be said that no such conversation exists, and surely, I have based the justification for my work on this claim. But, in keeping with the theoretical thread of the dissertation - the "absent presence" - I would also argue that the lack of a conversation is itself a conversation nonetheless. The paucity of scholarly and humanitarian discourse about men and pregnancy, save for the few focused book chapters and the many insinuations about men-as-risks, is in fact a din of assumptions about kinship, gender, space, and even race and ethnicity.

Limitations

There were a great deal of limitations to this project that I hope can be taken up and examined in the future, either by me or other researchers. (Currently, I know of only two, both of which are first-year PhD students planning to conduct similar research in India and the Democratic Republic of Congo.) Unfortunately, the research was so focused on the experiences of expectant fathers and their partners that I had few resources or time to explore *Bajenu Gox* by interviewing *bajen* and training facilitators or by attending training workshops. While I learned a

great deal about *accouchement humanisé*, I could not commit any more time to further investigation by interviewing employees of JICA or making a focused subcategory of case study couples who had actually followed through with *accouchement humanise* at *Hopital Central*. (Some had planned for it, but none had followed through.) While I tried for over 18 months to secure an interview with the Director of *La Direction de la Sante de la Mere et de l'Enfant* (Department of Mother and Child Health, or DSME) within MSAS, I was ultimately unsuccessful. I was able to speak with people in DMSE, but I wanted *his* perspective as a liaison between global health discourse and state implementation of programs like the development of the *carnet* and the successful launch and maintenance of *Bajenu Gox*. I feel that mitigating these three blindspots would have provided an even broader structural perspective.

Within the research that was conducted, there are other limitations. My intermediate Wolof skills severely handicapped my ability to conduct interviews with Wolophones who did not speak French. And while Fatimata was an excellent, experienced, and kind interviewer, I hired Babacar specifically because he required training. In the future, I may like to hire a larger team of researchers of various experiences who can aid each other. Further, while I was able to undertake some participant-observation in maternity wards, it proved difficult to teach the method to Fatimata and Babacar, let alone encourage them to go out and do it. Finally, I would have liked to follow-up with more couples and for longer periods of time. Couple were not always responsive when we called months after the first interviews - in some cases, phone numbers changed (which is normal), or couples moved back to natal villages, or men simply did not think there was anything further to discuss. If we'd been able to take more time to recruit couples at the beginning, thereby providing a larger pool from which to select cases, I would have liked to take more time at the end to follow up with many more couples over a longer

period of time. This would have been particularly helpful in assessing another global health indicator which I have not discussed here: infant survivability at 6 and 12 months and five years.

Future Research

Based on the work that I've done in Dakar and the arguments I've made here, there seems to me a natural progression into my next project. I credit Mohamed Ly for the eureka moment that night in the restaurant.

While linked thematically, my next project deviates substantially from the dissertation research, as I take a broad structural view of how what I think of as “humanitarian imperialism” manifests. I define humanitarian imperialism as the way that the global health community stays in business by avoiding the problems they claim to want to solve, very often with the willing assistance of state health administrations. As a point of departure, a fundamental ethnographic argument of this dissertation concludes that medical negligence and hospital nepotism have a greater impact on women and children's health outcomes than does a lack of men's involvement. In Chapter 8, I describe the political-economic lens through which men make sense of pregnancy loss and child death. It was during these difficult periods that men revealed their most cutting criticisms of hospital personnel and the Senegalese health system more broadly: that in addition to a paucity of resources, midwives were dangerously undertrained. Some of my contacts in MSAS agreed, suspecting that medical negligence and hospital nepotism are high because, as midwifery is a highly regarded, well-paid career path in high demand, post-graduate midwifery training in Dakar is rushed.

Over the next several years, I will explore the historical and political trajectories of state-trained midwives and *bajen* in Dakar along three axes: midwifery training, *Bajenu Gox* training,

and the relatively recent implementation of *accouchement humanisé* (humanized birth). As of 2009, the state has been training older, experienced lay women as neighborhood doulas (*Bajenu Gox*) to be maternal health educators and advisors to their pregnant neighbors, and they are more widely accepted. It is notable that this effort to offer a locally recognizable complement to the biomedical system of prenatal care evokes similar French colonial health interventions of the early 20th century that got women to show up to pre- and post-natal examinations. Further, as of 2017, there have been murmurs in MSAS about the development of a *Nijaayu Gox* program aimed at men - *nijaay*, meaning “uncle” - but there has been no traction as of yet in the launch of that program. Finally, I’m interested in looking at how the Japan International Cooperation Agency (JICA) has funded the import of a foreign model of humanized birth. From recent reports released by JICA, it seems that Senegalese women aren’t utilizing humanized birth facilities at the rates projected when the pilot project began in 2014, and I’m interested to know why.

In addition to interviewing pregnant couples about their lived experiences, I will shift my ethnographic focus to international aid agencies, state hospitals, health professionals, training staff, student midwives, and *bajen* in order to better understand how global and state health discourses discipline healthcare practitioners, and how they in turn discipline women into pregnant subjects in “good health.” I have already begun archival research at the *Institut Fondamental d’Afrique Noire* (Dakar, Senegal) and I aim to begin research at the *Archives Nationales d’Outre Mer* (Aix-en-Provence, France) in 2020-21.



Works Cited

- American Anthropological Association. 1947. *Statement on human rights: submitted to the Commission on Human Rights United Nations*. *American Anthropologist*. 49 (4).
- ANSD (Agence Nationale de la Statistique et de la Démographie). 2010. *Banque de Données des Indicateurs Sociaux du Sénégal (2007-2009)*. République du Sénégal.
- . 2014. *Recensement Général de la Population et de l'Habitat, de l'Agriculture et de l'Élevage (RGPHAE 2013)*. République du Sénégal.
- . 2015a. *Rapport Projection de la Population du Sénégal (2013-2063)*: Direction des Statistiques Démographiques et Sociales. République du Sénégal.
- . 2015b. *Situation Economique et Sociale du Sénégal en 2012*. République du Sénégal.
- Abu-Lughod, Lila. 2002. Do Muslim Women Really Need Saving?: Anthropological Reflections on Cultural Relativism and Its Others. *American Anthropologist*. 104 (3): 783-790.
- . 2012. Authorizing Moral Crusades to Save Muslim Women. The Tenth Farhat J. Ziadeh Distinguished Lecture in Arab and Islamic Studies. April 30, 2012. The Department of Near Eastern Languages and Civilization at the University of Washington.
- . 2013. *Do Muslim Women Need Saving?* Cambridge, MA: Harvard University Press.
- Adams, Vincanne. 2016. Metrics of the Global Sovereign: Numbers and Stories in Global Health. In *Metrics: What Counts in Global Health*. Vincanne Adams, ed. Pp 20-54. Durham: Duke University Press.
- Adjamagbo, Agnès and Pierrette Aguessy Koné. 2013. "Situations Relationnelles et Gestion des Grossesses Non Prévues à Dakar." *Population*. 68 (1): 67-96.
- Amin, Samir. 2006. "Review of the Month - The Millennium Development Goals: A Critique from the South". *Monthly Review*. 57 (10): 1.
- Assaf, Shireen, and Lwendo Moonzwe Davis. 2018. *Does Men's Involvement Improve the Health Outcomes of Their Partners and Children?* <https://purl.fdlp.gov/GPO/gpo112819>.
- Aubel, Judi, Ibrahima Touré, and Mamadou Diagne. 2004. "Senegalese Grandmothers Promote Improved Maternal and Child Nutrition Practices: The Guardians of Tradition are not Averse to Change," *Social Science and Medicine*. 59 (5): 945-959.
- Babou, Cheikh Anta Mbacké. 2007. "Urbanizing Mystical Islam: Making Murid Space in the Cities of Senegal". *International Journal of African Historical Studies*. 40 (2): 197-223.

- Barry, Boubacar. 1998. *Senegambia and the Atlantic slave trade*. Cambridge, U.K.: Cambridge University Press.
- . 1999. Senegambia from the 16th to the 18th Century: The Wolof, Sereer and "Tukuloor". In *Africa from the Sixteenth to the Eighteenth Century*. Bethwell A. Ogot, ed. Pp. 263-299. Oxford: J. Currey.
- . 2012. *The Kingdom of Waalo: Senegal before the Conquest*. New York: Diasporic Africa Press.
- Berman, Elise. 2014. "Holding on: adoption, kinship tensions, and pregnancy in the Marshall Islands". *American Anthropologist*. 116 (3): 578-590.
- Betts, Raymond F. 1961. *Assimilation and Association in French Colonial Theory, 1890-1914*. New York: Columbia University Press.
- . 1971. The Establishment of the Medina in Dakar, Senegal, 1914. *Africa: Journal of the International African Institute* 41(2): 143–152.
- . 1985. Dakar: Ville Impériale (1857–1960). In *Colonial Cities*. Robert J. Ross and Gerard J. Telkamp, eds. Pp. 193–206. *Comparative Studies in Overseas History*, 5. Springer Netherlands.
- Boserup, Ester. 1970. *Woman's Role in Economic Development*. New York: St. Martin's Press.
- Bourdieu, Pierre. 1977. *Outline of a Theory of Practice*. Cambridge, U.K.: Cambridge.
- . 2001. *Masculine Domination*. Stanford, Calif: Stanford University Press.
- Brennan, Arthur, Susan Ayers, Hafez Ahmed, and Sylvie Marshall-Lucette. 2007. A Critical Review of the Couvade Syndrome: The Pregnant Male. *Journal of Reproductive and Infant Psychology*. 25 (3): 173-189.
- Brodsky, Mitchell S. 1999. "The Young Male Experience with Treatment for Nonseminomatous Testicular Cancer". *Sexuality and Disability : A Journal Devoted to the Psychological and Medical Aspects of Sexuality in Rehabilitation and Community Settings*. 17 (1): 65-77.
- Browner, Carole H. 1983. "Male pregnancy symptoms in urban Colombia". *American Ethnologist*. 494-510.
- Buggenhagen, Beth. 2001. Prophets and Profits: Gendered and Generational Visions of Wealth and Value in Senegalese Murid households. *Journal of Religion in Africa*. 31 (4): 373-401.
- . 2011. "Are births just 'women's business'? Gift Exchange, Value, and Global Volatility in Muslim Senegal." *American Ethnologist*. 38 (4): 714-732.
- . 2012. *Muslim Families in Global Senegal: Money Takes Care of Shame*. Bloomington, IN: Indiana University Press.

- Butler, Judith. 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.
- . 1993. *Bodies That Matter: On the Discursive Limits of "Sex"*. New York: Routledge.
- CRSD. 2015. *Argumentaire islamique sur l'espacement des naissances*. Washington DC: World Faiths Development Dialogue International, Inc.
- Campbell, Nancy D., and Susan J. Shaw. 2008. "Incitements to Discourse: Illicit Drugs, Harm Reduction, and the Production of Ethnographic Subjects". *Cultural Anthropology*. 23 (4): 688-717.
- Carrigan, Tim, R.W. Connell, and John Lee. 1985. "Toward a New Sociology of Masculinity." *Theory and Society*. 14(5): 551–604.
- Chary, Anita, Sarah Messmer, Eric Sorenson, Nicole Henretty, Shom Dasgupta, and Peter Rohloff. 2013. "The normalization of childhood disease: an ethnographic study of child malnutrition in rural Guatemala". *Human Organization*. 72 (2): 87-97.
- Cleland, John G., and Jerome K. van Ginneken. 1988. "Maternal education and child survival in developing countries: The search for pathways of influence". *Social Science & Medicine*. 27 (12): 1357-1368.
- Connell, R.W. 2005. *Masculinities*. Berkeley, Calif: University of California Press.
- Connell, R.W., and James W. Messerschmidt. 2005. "Hegemonic Masculinity Rethinking the Concept." *Gender & Society*. 19(6): 829–859.
- Crowder, Michael. 1962. *Senegal: A Study of French Assimilation Policy*. London: Methuen.
- Cruise O'Brien, Donal. 1998. The Shadow-Politics of Wolofisation. *The Journal of Modern African Studies*. 36 (1): 25-46.
- Dankoko, Boubacar Samba. 2012. The Evolution of the Population in Senegal. *In Population Trends and Policy Options in Selected Developing Countries*. Joe Thomas, ed. Pp. 190-201. Dhaka, Bangladesh: Partners in Population and Development.
- Davids, Tine, Francien van Driel, and Anouka van Eerdewijk. 2011. "Governmentalities and Moral Agents in the Local/Global Nexus: Male Premarital Sexuality in Dakar, Senegal." *Globalizations*. 8 (2): 197-211.
- Datta, Kavita. 2004. A Coming of Age?: Re-Conceptualising Gender and Development in Urban Botswana. *Journal of Southern African Studies*. 30 (2): 251-268.
- Davis-Floyd, Robbie E., Lesley Barclay, and Jan Tritten. 2009. *Birth Models That Work*. University of California Press.
- Davis-Floyd, Robbie E., and Joseph Dumit. 1998. *Cyborg Babies: From Techno-Sex to Techno-*

- Tots*. London: Routledge.
- Deomampo D. 2013. "Transnational surrogacy in india: Interrogating power and women's agency". *Frontiers*. 34 (3): 167-188.
- Desgrées-du-Loû A, and H Brou. 2005. "Resumption of sexual relations following childbirth: norms, practices and reproductive health issues in Abidjan, Côte d'Ivoire". *Reproductive Health Matters*. 13 (25): 155-63.
- Diop, Abdoulaye-Bara. 1985. *La Famille Wolof: Tradition et Changement*. Paris: Karthala.
- Diouf, Mamadou. 1998. The French Colonial Policy of Assimilation and the Civility of the 'Originaires' of the Four Communes (Senegal): A Nineteenth Century Globalization Project. *Development and Change*. 29 (4): 671-696.
- . 2003. Engaging Postcolonial Cultures: African Youth and Public Space. *African Studies Review*. 46(2):1-12.
- Doja, Albert. 2005. Rethinking the Couvade. *Anthropological Quarterly*. 78 (4): 917-950.
- Douglas, Mary. 1968. "The Relevance of Tribal Studies." *Journal of Psychosomatic Research*. 12 (1): 21-28.
- Dudgeon, Matthew R., and Marcia C. Inhorn. 2003. "Gender, Masculinity, and Reproduction: Anthropological Perspectives." *International Journal of Men's Health*. 2(1).
- . 2004. "Men's Influences on Women's Reproductive Health: Medical Anthropological Perspectives." *Social Science & Medicine*. (1982) 59(7): 1379–1395.
- Edwin, Shirin. 2004. "African Muslim Communities in Diaspora: The Quest For A Muslim Space In Ken Bugul's Le Baobab fou." *Research in African Literatures*. 35 (4): 75-90.
- Erickson, Pamela I., Louise Badiane, and Merrill Singer. 2013. "The Social Context and Meaning of Virginity Loss among African American and Puerto Rican Young Adults in Hartford". *Medical Anthropology Quarterly*. 27 (3): 313-329.
- Escobar, Arturo. 1995. *Encountering Development: The Making and Unmaking of the Third World*. Princeton, N.J.: Princeton University Press.
- Ferguson, James. 1990. *The Anti-Politics Machine: "Development", Depoliticization, and Bureaucratic power in Lesotho*. Cambridge: Cambridge University Press.
- Foley, Ellen E. 2010. *Your Pocket is What Cures You: The Politics of Health in Senegal*. New Brunswick, N.J.: Rutgers University Press.
- Foley, Ellen E., and Fatou Maria Drame. 2013. "Mbaraan and the Shifting Political Economy of Sex in Urban Senegal." *Culture, Health & Sexuality*. 15 (2): 121-134.

- Fonseca, Claudia. 2011. Law, Technology, and Gender Relations: Following the Path of DNA Paternity Tests in Brazil. In *Reproduction, Globalization, and the State: New Theoretical and Ethnographic Perspectives*. Carole H. Browner and Carolyn F. Sargent, eds. Pp. 139-153. Durham, NC: Duke University Press.
- Foucault, Michel. 1975. *Discipline and Punish*. London: Penguin.
- Fullwiley, Duana. 2010. "Revaluating Genetic Causation: Biology, Economy, and Kinship in Dakar, Senegal." *American Ethnologist*. 37: 638-661.
- . 2011. *The Enculturated Gene: Sickle Cell Health Politics and Biological Difference in West Africa*. Princeton, New Jersey: Princeton University Press.
- Gakidou, Emmanuela, Krycia Cowling, Rafael Lozano, and Christopher JL Murray. 2010. "Increased Educational Attainment and its Effect on Child Mortality in 175 Countries between 1970 and 2009: A Systematic Analysis". *The Lancet*. 376 (9745): 959-974.
- Garro, Linda C. 1998. "On the Rationality of Decision-Making Studies: Part 1: Decision Models of Treatment Choice". *Medical Anthropology Quarterly*. 12 (3): 319.
- Gellar, Sheldon. 2005. *Democracy in Senegal: Tocquevillian Analytics in Africa*. New York: Palgrave Macmillan.
- Genova, James E. 2004. Conflicted Missionaries: Power and Identity in French West Africa During the 1930s. *Historian* 66(1): 45–66.
- Gettler, Lee T., Thomas W. McDade, and Christopher W. Kuzawa. 2011. "Cortisol and testosterone in Filipino young adult men: evidence for co-regulation of both hormones by fatherhood and relationship status". *American Journal of Human Biology*. 23 (5): 609-620.
- Han, Sallie. 2009. "Making Room for Daddy: Men's 'Belly Talk' in the Contemporary United States." In *Reconceiving the Second Sex: Men, Masculinity, and Reproduction*. Marcia C. Inhorn, Tine Tjørnhøj-Thomsen, Helene Goldberg, and Maruska la Cour Mosegaard eds. Pp. 305–326. New York: Berghahn Books.
- . 2015. *Pregnancy in practice: expectation and experience in the contemporary US*. New York: Berghahn Books.
- Hannaford, Dinah. 2015. "Technologies of the Spouse: Intimate Surveillance in Senegalese Transnational Marriages." *Global Networks*. 15 (1): 43-59.
- Hannaford, Dinah, and Ellen E. Foley. 2015. "Negotiating Love and Marriage in Contemporary Senegal: A Good Man is Hard to Find." *African Studies Review*. 58 (2): 205-225.
- Harkness, Sara. 1987. "The Cultural Mediation of Postpartum Depression". *Medical Anthropology Quarterly : International Journal for the Cultural and Social Analysis of Health*.
- Hegel, Georg Wilhelm Friedrich. 2001. *The Philosophy of History*. Kitchener, Ont: Batoche.

- Heinonen, Nea-Mari. 2006. Gender and Development – No-Man’s Land Revisited: Learning from Men’s Inclusion Discourse and Practice in Uganda. M.A. Thesis, School of Modern Languages and Translation Studies, University of Tampere.
- Hewlett, Barry S. 1987. Sexual Selection and Paternal Investment among Aka Pygmies. In *Human reproductive behaviour: a Darwinian perspective*. Laura L. Betzig, Monique Borgerhoff Mulder, and Paul Turke, eds. Pp. 263-276. Cambridge [Cambridgeshire]: Cambridge University Press.
- . 1994. *Intimate fathers: the nature and context of Aka pygmy paternal infant care*. Ann Arbor, Mich: University of Michigan Press.
- Hildebrand, Vanessa M. 2012. "Scissors as Symbols: Disputed Ownership of the Tools of Biomedical Obstetrics in Rural Indonesia". *Culture, Medicine and Psychiatry*. 36 (3): 557-570.
- Hill, Joseph. 2014. Picturing Islamic Authority: Gender Metaphors and Sufi Leadership in Senegal. *Islamic Africa*. 5 (2): 275-315.
- Hoffman, Barbara G. 2014. *Being Maasai Today. Three Maasai women have their say (Extended Version, 2014) Part 1, Part 1*. <http://www.aspresolver.com/aspresolver.asp?MARC;3190435>.
- Hörbst, Viola, and Angelika Wolf. 2014. "ARVs and ARTs: Medicoscapes and the Unequal Place-making for Biomedical Treatments in sub-Saharan Africa". *Medical Anthropology Quarterly*. 28 (2): 182-202.
- Inhorn, Marcia C. 2003. *Local Babies, Global Science: Gender, Religion, and in vitro Fertilization in Egypt*. New York: Routledge.
- Inhorn, Marcia C., Tine Tjørnhøj-Thomsen, Helene Goldberg, and la Cour Mosegaard, eds. 2009. *Reconceiving the Second Sex: Men, Masculinity, and Reproduction*. New York: Berghahn Books.
- Inhorn, Marcia C., and Emily A. Wentzell. 2011. "Embodying Emergent Masculinities: Men Engaging with Reproductive and Sexual Health Technologies in the Middle East and Mexico." *American Ethnologist*. 38 (4): 801-815.
- Ivry, Tsipy. 2009. "'We Are Pregnant': Israeli Men and the Paradox of Sharing." In *Reconceiving the Second Sex: Men, Masculinity, and Reproduction*. Marcia C. Inhorn, Tine Tjørnhøj-Thomsen, Helene Goldberg, and Maruska la Cour Mosegaard eds. Pp. 281–304. New York: Berghahn Books.
- Johnson, Nancy Kwang. 2004. Senegalese "Into Frenchmen"? The French Technology of Nationalism in Senegal. *Nationalism and Ethnic Politics*. 10 (1): 135-158.
- Johnson, G. Wesley. 1971. *The Emergence of black politics in Senegal*. Stanford: Cal., Stanford University Press.

- Johnson-Hanks, Jennifer. 2006. *Uncertain Honor: Modern Motherhood in an African Crisis*. Chicago: University of Chicago Press.
- Jordan, Brigitte. 1997. Authoritative Knowledge and its Construction. In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. Robbie E. Davis-Floyd and Carolyn F. Sargent, eds. Pp. 55-79. Berkeley, Calif: University of California Press.
- Kazmierczak M., Pastwa-Wojciechowska B., Kielbratowska B., and Preis K. 2013. Couvade Syndrome among Polish Expectant Fathers. *Medical Science Monitor*. 19 (1): 132-138.
- Ketler, Suzanne K. 2000. "Preparing for Motherhood: Authoritative Knowledge and the Undercurrents of Shared Experience in Two Childbirth Education Courses in Cagliari, Italy". *Medical Anthropology Quarterly*. 14 (2): 138-158.
- Kupferer, Harriet Jane. 1965. "Couvade: Ritual or Real Illness." *American Anthropologist*. 67 (1): 99-102.
- Kusiak, Pauline. 2010a. "Instrumentalized Rationality, Cross-Cultural Mediators, and Civil Epistemologies of Late Colonialism." *Social Studies of Science*. 40 (6): 871-902.
- . 2010b. "'Tubab' Technologies and 'African' Ways of Knowing: Nationalist Techno-Politics in Senegal." *History and Technology*. 26.
- Layne, Linda L. 2003. *Motherhood Lost: A Feminist Account of Pregnancy Loss in America*. New York: Routledge.
- Law, John. 2004. *After Method: Mess in Social Science Research*. London: Routledge.
- Law, John, and Annemarie Mol. 1995. "Notes on materiality and sociality". *The Sociological Review*. 43 (2): 274.
- Levy, Robert I. and Douglas W. Hollan. 2015. Person-Centered Interviewing and Observation. In *Handbook of methods in cultural anthropology*. H. Russell Bernard and Clarence Gravelee, eds. Pp. 313-342. Lanham, Md.: Rowman et Littlefield.
- Lindo, Karen. 2010. "Ousmane Sembène's Hall of Men: (En)gendering Everyday Heroism." *Research in African Literature*. 41: 109-124.
- Lock, Margaret M. 1993. *Encounters with aging: mythologies of menopause in Japan and North America*. Berkeley: University of California Press.
- MSAS. 2018. *Documentation du processus de mise en œuvre du modèle du projet de renforcement des soins de santé maternelle et néonatale (PRESSMN)*.
- M'charek, A., K. Schramm, and D. Skinner. 2014a. "Technologies of belonging: the absent presence of race in Europe". *Science, Technology, & Human Values*. 39 (4): 459-467.

- . 2014b. "Topologies of race: doing territory, population and identity in Europe". *Science, Technology, & Human Values*. 39 (4): 468-487.
- Malamud, Margaret. 1996. Gender and Spiritual Self-Fashioning: The Master-Disciple Relationship in Classical Sufism. *Journal of the American Academy of Religion*. 64 (1): 89-117.
- Maes, Kenneth. 2015. "Community health workers and social change: An introduction". *Annals of Anthropological Practice*. 39 (1): 1-15.
- Mamdani, Mahmood. 1996. *Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism*. Princeton, N.J: Princeton University Press.
- Mamo, Laura. 2007. *Queering reproduction: achieving pregnancy in the age of technoscience*. Durham, N.C.: Duke University Press.
- Mbow, Penda. 2008. Senegal: The Return of Personalism. *Journal of Democracy*. 19 (1): 156-169.
- McKenna, James J., Helen L. Ball, and Lee T. Gettler. 2007. "Mother-infant cosleeping, breastfeeding and sudden infant death syndrome: What biological anthropology has discovered about normal infant sleep and pediatric sleep medicine". *American Journal of Physical Anthropology*. 134 (S45): 133-161.
- Meda, Nicolas, Ibra Ndoeye, Souleymane M'Boup, Alpha Wade, Salif Ndiaye, Cheikh Niang, Fatou Sarr, Idrissa Diop, and Michael Caraël. 1999. "Low and stable HIV infection rates in Senegal natural course of the epidemic or evidence for success of prevention?" *AIDS*. 13 (11): 1397-1405.
- Melly, Caroline. 2010. Inside-out Houses: Urban Belonging and Imagined Futures in Dakar, Senegal. *Comparative Studies in Society and History*. 52(1):37-65.
- . 2011. "Titanic Tales of Missing Men: Reconfigurations of National Identity and Gendered Presence in Dakar, Senegal." *American Ethnologist*. 38 (2): 351-376.
- Mendoza Denton, Norma, and Aomar Boum. 2015. "Breached initiations". *Annual Review of Anthropology*. 295-310.
- Middelthon, Anne-Lise. 2001. Interpretations of Condom Use and Nonuse among Young Norwegian Gay Men: A Qualitative Study. *Medical Anthropology Quarterly*. 15 (1): 58-83.
- Miles, Matthew B., and A. Michael Huberman. 1994. *Qualitative data analysis: an expanded sourcebook*. Thousand Oaks: Sage.
- Miller, Janneli F. 2009. "Husband-Assisted Birth among the Raramuri of Northern Mexico." In *Reconceiving the Second Sex: Men, Masculinity, and Reproduction*. Marcia C. Inhorn, Tine Tjørnhøj-Thomsen, Helene Goldberg, and Maruska la Cour Mosegaard eds. Pp. 327–348. New York: Berghahn Books.

- Mishtal, Joanna. 2010. "Neoliberal reforms and privatisation of reproductive health services in post-socialist Poland". *Reproductive Health Matters*. 18 (36): 56-66.
- Mol, Annemarie. 2002. *The Body Multiple: Ontology in Medical Practice*. Durham, N.C.: Duke University Press.
- Moland, Karen Marie and Astrid Blystad. 2009. Counting on Mother's Love: The Global Politics of Prevention of Mother-to-Child Transmission of HIV in Eastern Africa. In *Anthropology and Public Health: Bridging Differences in Culture and Society*. Robert A. Hahn and Marcia C. Inhorn, eds. Pp. 447-479. Oxford: Oxford University Press.
- Morris, Rosalind C. 1995. "All Made Up: Performance Theory and the New Anthropology of Sex and Gender." *Annual Review of Anthropology*. 24: 567-592.
- Mosegaard, Maruska la Cour. 2009. Stories of Fatherhood: Kinship in the Making. In *Reconceiving the Second Sex: Men, Masculinity, and Reproduction*. Marcia C. Inhorn, Tine Tjørnhøj-Thomsen, Helene Goldberg, and Maruska la Cour Mosegaard eds. Pp. 349–370. New York: Berghahn Books.
- Musante, Kathleen. 2015. "Participant Observation." In *Handbook of Methods in Cultural Anthropology*. H. Russell Bernard and Clarence C. Gravlee, eds. Pp. 251—292. Lanham, MD: Rowman & Littlefield.
- Mushengyezi, Aaron. 2004. "Reimagining Gender and African Tradition?: Ousmane Sembène's 'Xala' Revisited." *Africa Today*. 51 (1): 47-62.
- Ndao, Mor. 2008. "Colonisation et Politique de Santé Maternelle et Infantile au Sénégal (1905-1960)." *French Colonial History*. 9 (1): 191-211.
- Ndiaye, Lamine. 2009. *Parenté et Mort chez les Wolof: Traditions et Modernité au Sénégal*. Paris: Harmattan.
- Newman, Lucile. 1966. The Couvade: A Reply to Kupferer. *American Anthropologist*. 68 (1): 153-156.
- Ngalamulume, Kalala J. 2004. Keeping the City Totally Clean: Yellow Fever and the Politics of Prevention in Colonial Saint-Louis-du-Sénégal, 1850-1914. *The Journal of African History*. 45 (2): 183-202.
- . 2012. *Colonial Pathologies, Environment, and Western Medicine in Saint-Louis-du-Senegal, 1867-1920*. New York: Peter Lang.
- Niang, Cheikh Ibrahima, Placide Tapsoba, Ellen Weiss, Moustapha Diagne, Youssoupha Niang, Amadou Mody Moreau, Dominique Gomis, Abdoulaye Sidbé Wade, Karim Seck, and Chris Castle. 2003. "It's Raining Stones": Stigma, Violence and HIV Vulnerability among Men who have Sex with Men in Dakar, Senegal. *Culture, Health & Sexuality*. 5 (6): 499-512.

- Okigbo CC, IS Speizer, M Corroon, and A Gueye. 2015. "Exposure to Family Planning Messages and Modern Contraceptive Use among Men in Urban Kenya, Nigeria, and Senegal: A Cross-Sectional Study." *Reproductive Health*. 12(63).
- Oliffe John L., John Ogrodniczuk, Joan L. Bottorff, T. Gregory Hislop, and Michael Halpin. 2009. "Connecting humor, health, and masculinities at prostate cancer support groups". *Psycho-Oncology*. 18 (9): 916-26.
- Orozco, Manuel, Elisabeth Burgess, and Corinne Massardier. 2010. *Remittance Transfers in Senegal: Preliminary Findings, Lessons, and Recommendations on Its Marketplace and Financial Access Opportunities*. Geneva: ILO.
- Parikh, Shanti. 2015. *Regulating romance youth love letters, moral anxiety, and intervention in Uganda's time of AIDS*. Nashville: Vanderbilt University Press.
- Patterson, Donna A. 2015. *Pharmacy in Senegal: Gender, Healing, and Entrepreneurship*. Bloomington: Indiana University Press.
- Perry, Donna L. 2004. "Muslim Child Disciples, Global Civil Society, and Children's Rights in Senegal: The Discourses of Strategic Structuralism." *Anthropological Quarterly*. 77 (1): 47-86.
- . 2005. "Wolof Women, Economic Liberalization, and the Crisis of Masculinity in Rural Senegal." *Ethnology*. 44(3): 207-226.
- . 2009. "Fathers, Sons, and the State: Discipline and Punishment in a Wolof Hinterland." *Cultural Anthropology*. 24 (1): 33-67.
- Pigg, Stacy Leigh. 1997. Authority in Translation: Finding, Knowing, Naming, and Training "Traditional Birth Attendants" in Nepal. In *Childbirth and authoritative knowledge: cross-cultural perspectives*. Robbie E. Davis-Floyd and Carolyn F. Sargent, eds. Pp. 233-262. Berkeley, Calif: University of California Press.
- Poteat, Tonia, Daouda Diouf, Fatou Maria Drame, Marieme Ndaw, Cheikh Traore, Mandeep Dhaliwal, Chris Beyrer, and Stefan Baral. 2011. HIV Risk among MSM in Senegal: A Qualitative Rapid Assessment of the Impact of Enforcing Laws That Criminalize Same Sex Practices. Public Library of Science. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3237497/>
- Powis, Richard. 2016. "Enduring Precarity: Emergent Masculinities and Rethinking Couvade in Dakar, Senegal". *Proceedings of the African Futures Conference*. 1 (1): 197-202.
- Premberg, Åsa, Gunilla Carlsson, Anna-Lena Hellström, and Marie Berg. 2011. "First-time fathers' experiences of childbirth—A phenomenological study". *Midwifery*. 27 (6): 848-853.
- The Prevention of Maternal Mortality Network. 1992. "Barriers to treatment of obstetric emergencies in rural communities of West Africa". *Studies in Family Planning*. 23 (5).
- Prince, Ruth J. 2014. *Situating Health and the Public in Africa: Historical and Anthropological*

- Perspectives. In *Making and Unmaking Public Health in Africa: Ethnographic and Historical Perspectives*. Ruth J. Prince and Rebecca Marsland, eds. Pp. 1-51. Athens: Ohio University Press.
- Quist-Arcton, Ofeibe. 2011. "In Senegal, The Grandmas Are In Charge." NPR. Published August 11, 2011. <https://www.npr.org/2011/08/11/139543928/in-senegal-the-grandmas-are-in-charge>
- Ralph, Michael. 2008. Killing Time. *Social Text*. 97:1-29.
- . 2015. *Forensics of Capital*. Chicago : University of Chicago Press.
- Rapp, Rayna. 1999. *Testing women, testing the fetus: the social impact of amniocentesis in America*. London: Routledge.
- Reed, Richard K. 2005. *Birthing Fathers: The Transformation of Men in American Rites of Birth*. New Brunswick, N.J.: Rutgers University Press.
- Ribeiro, Gustavo Lins, and Arturo Escobar, eds. 2006. *World Anthropologies: Disciplinary Transformations in Systems of Power*. Oxford, UK ; New York: Bloomsbury Academic.
- Richard, Francois Gilles. 2007. *From Cosaan to Colony: Exploring Archaeological Landscape Formations and Socio-Political Complexity in the Siin (Senegal), AD 500-1900*. Ph.D. dissertation, Department of Anthropology, Syracuse University.
- Rival, Laura. 1998. Androgynous parents and guest children: the Huaorani couvade. *Journal of the Royal Anthropological Institute*. 4(4):619-642.
- Rivière, Peter G. 1974. "The Couvade: A Problem Reborn." *Man*. 9: 423-435.
- Roberts, Elizabeth F. S. 2012. *God's Laboratory: Assisted Reproduction in the Andes*. Berkeley: University of California Press.
- Rosen, Willow. 2019. Queer and Trans Babymaking as Told by the People Who Do It." Presentation. Transgender Spectrum Conference, Washington University in St. Louis. November 8.
- Ross, Bob, and Michelle Witte. 2017. *Happy little accidents: the wit and wisdom of Bob Ross*. Philadelphia: Running Press.
- Sánchez Rodríguez, Susana, Peláez del Hierro, Fernando, Fidalgo de las Heras, Ana María, Morcillo Pimentel, Ana, and Caperos Montalbán, José Manuel. 2008. "Body weight increase in expectant males and helpers of cotton-top tamarin (*Saguinus oedipus*): A symptom of the Couvade syndrome?" *Psicothema*. 20 (4): 825-9.
- Sangaramoorthy, Thurka, and Karen Kroeger. 2013. Mobility, Latino migrants, and the geography of sex work: using ethnography in public health assessments. *Human Organization*. 72 (3): 263-272.

- Sargent, Carolyn. 2006. "Reproductive Strategies and Islamic Discourse." *Medical Anthropology Quarterly*. 20 (1): 31-49.
- . 2011. Problematizing Polygamy, Managing Maternity: Intersections of Global, State, and Family Politics in the Lives of West African migrant women in France. *In* Globalization, Reproduction, and the State. Carole Browner and Carolyn Sargent, eds. Durham, NC: Duke University Press.
- Sargent, Carolyn, and Nancy Stark. 1989. "Childbirth Education and Childbirth Models: Parental Perspectives on Control, Anesthesia, and Technological Intervention in the Birth Process". *Medical Anthropology Quarterly*. 3 (1): 36-51.
- Scheper-Hughes, Nancy, and Margaret M. Lock. 1987. "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology". *Medical Anthropology Quarterly*. 1 (1): 6-41.
- Schumm, Kate, Zoe Skea, Lorna McKee, and James N'Dow. 2010. "They re doing surgery on two people : a meta ethnography of the influences on couples treatment decision making for prostate cancer". *Health Expectations*. 13 (4): 335-349.
- Seligmann, Linda J. 2009. The Cultural and Political Economies of Adoption Practices in Andean Peru and the United States. *Journal of Latin American and Caribbean Anthropology*. 14 (1): 115-139.
- Seigel, Marika. 2013. *The rhetoric of pregnancy*. Chicago: University of Chicago Press.
- Sharpe, Jenny, and Gayatri Chakravorty Spivak. 2003. "A Conversation with Gayatri Chakravorty Spivak: Politics and the Imagination". *Signs*. 28: 609-624.
- Sidze, E.M., S. Lardoux, I.S. Speizer, C.M. Faye, M.M. Mutua, and F. Badji. 2014. "Young Women's Access to and Use of Contraceptives: The Role of Providers' Restrictions in Urban Senegal." *International Family Planning Perspectives*. 40 (4): 176-183.
- Spivak, Gayatri Chakravorty. 1987. *In Other Worlds: Essays in Cultural Politics*. New York: Methuen.
- . 2006. Can the Subaltern Speak? *In* The Post-Colonial Studies Reader. Bill Ashcroft, Gareth Griffiths, and Helen Tiffin, eds. Pp. 28-37. New York: Routledge.
- Steward, Julian H. 1948. "Brief Communications". *American Anthropologist*. 50 (2): 351-352.
- Stern Gwen, and Laurence Kruckman. 1983. "Multi-disciplinary perspectives on post-partum depression: an anthropological critique". *Social Science & Medicine (1982)*. 17 (15): 1027-41.
- Stevenson, Lisa. 2014. *Life beside itself: imagining care in the canadian arctic*. Oakland: University of California Press.
- Storeng, Katerini T., and Dominique Béhague. 2014. "'Playing the numbers game": evidence-based advocacy and the technocratic narrowing of the Safe Motherhood Initiative". *Medical*

- Anthropology Quarterly*. 28 (2): 260-279.
- Storeng, Katerini T., and Fatoumata Ouattara. 2014. "The politics of unsafe abortion in Burkina Faso: The interface of local norms and global public health practice". *Global Public Health*. 9 (8): 946-959.
- Taylor, Janelle S. 2008. *The public life of the fetal sonogram: technology, consumption, and the politics of reproduction*. New Brunswick, N.J.: Rutgers University Press.
- Teman, Elly. 2010. *Birthing a mother: the surrogate body and the pregnant self*. Berkeley: University of California Press.
- Thaddeus, Sreen, and Deborah Maine. 1994. "Too far to walk: Maternal mortality in context". *Social Science & Medicine*. 38 (8): 1091-1110.
- Tichenor, Marlee. 2016. The Power of Data: Global Malaria Governance and the Senegalese Data Retention Strike. In *Metrics: What Counts in Global Health*. Vincanne Adams, ed. Pp 106-124. Durham: Duke University Press.
- Treichler, Paula A. 1990. Feminism, Medicine, and the Meaning of Childbirth. In *Body/politics: women and the discourses of science*. Evelyn Fox Keller, Sally Shuttleworth, and Mary Jacobus, eds. Pp. 113-138. London, UK: Routledge.
- Tylor, Edward Burnett. 1865. *Researches into the early history of mankind and the development of civilization*. London: J. Murray.
- . 1889. On a method of investigating the development of institutions applied to laws of marriage and descent. London: Harrison.
- USAID. 2012. *Gender Equality and Female Empowerment Policy*.
https://www.usaid.gov/sites/default/files/documents/1865/GenderEqualityPolicy_0.pdf
- Villalón, Leonardo Alfonso. 1995. *Islamic Society and State Power in Senegal: Disciples and Citizens in Fatick*. New York: Cambridge University Press.
- . 1999. Generational Changes, Political Stagnation, and the Evolving Dynamics of Religion and Politics in Senegal. *Africa Today*. 46 (3/4): 129-147.
- Walks, Michelle, and Trevor MacDonald, MaryLynne Biener, and Alanna Kibbe. 2019. "Seeing men make perinatal decisions: Trans masculine individuals, intersectionality, and agency." Paper presented at the Annual Meeting of the American Anthropological Association. Vancouver, BC. November 22.
- Wall, Lewis L. 1999. "Dead Mothers and Injured Wives: The Social Context of Maternal Morbidity and Mortality among the Hausa of Northern Nigeria." *Sage Family Studies Abstracts*. 21 (2).
- Weber, Eugen Joseph. 1976. *Peasants into Frenchmen: the modernisation of Rural France*,

1870-1914. Stanford, Calif: Stanford University Press.

Wentzell, Emily. 2015a. "Enhancing Fathering through Medical Research Participation in Mexico." In *Globalized Fatherhood*. Inhorn, Marcia Claire, Wendy Chavkin, and José-Alberto Navarro, eds. New York: Berghahn.

———. 2015b. "Medical Research Participation as Citizenship: Modeling Modern Masculinity and Marriage in a Mexican Sexual Health Study." *American Anthropologist*. 117 (4): 652-664.

Wilder, Gary. 2005. *The French Imperial Nation-State: Negritude and Colonial Humanism between the Two World Wars*. Chicago: University Of Chicago Press.

———. 2015. *Freedom Time: Negritude, Decolonization, and the Future of the World*. Durham ; London: Duke University Press Books.

Willen, Sarah S. 2010. Darfur through a Shoah Lens: Sudanese Asylum Seekers, Unruly Biopolitical Dramas, and the Politics of Humanitarian Compassion in Israel. In *A reader in medical anthropology Theoretical trajectories emergent realities*. Byron J. Good, Michael M. J. Fischer, Sarah S. Willen, and Mary-Jo DelVecchio Good, eds. Chichester: Wiley.

Wright, Zachary Valentine. 2013. Islam and Decolonization in Africa: The Political Engagement of a West African Muslim Community. *The International Journal of African Historical Studies*. 46 (2): 205-227.

Wynn, L. L., and James Trussell. 2006. The Social Life of Emergency Contraception in the United States: Disciplining Pharmaceutical Use, Disciplining Sexuality, and Constructing Zygotic Bodies. *Medical Anthropology Quarterly*. 20 (3): 297-320.

Young, Sharon, and Daniel Benyshek. 2010. In Search of Human Placentophagy: A Cross-Cultural Survey of Human Placenta Consumption, Disposal Practices, and Cultural Beliefs. *Ecology of Food and Nutrition*. 49 (6): 467-484.

Yu, Yeon Jung. 2013. Subjectivity, Hygiene, and STI Prevention: A Normalization Paradox in the Cleanliness Practices of Female Sex Workers in Post-Socialist China. *Medical Anthropology Quarterly*. 27 (3): 348-367.