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To Be Delivered: Pregnant and Born Again in Nigeria

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To Be Delivered: Pregnant and Born Again in Nigeria

by

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[redacted]

In memory of B.A. Oni-Orisan, Funmi Fashina, and Dami Fashina.

For Adelona, Adelola, and Adebeni, the next generation of Oni-Orisan queens. In the words of Janelle Monae, may you be “powerful with a little bit of tender.” And may this world be ready for the magic you have in store for them.

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To Be Delivered: Pregnant and Born-Again in Nigeria
Adeola Oni-Orisan

Religious conversion has long paralleled development schemes in Africa with reproductive health interventions being a particularly dense node of interaction. However, only recently have *mission homes*, designated spaces within Pentecostal churches for women to receive perinatal care and deliver their babies, brought church and state into confrontation over how and where women should deliver. As global health agencies pledge to decrease maternal death by aiming to increase access to biomedical interventions in the form of *Safe Motherhood* initiatives, mission homes offer women prayer and the promise of divine intervention as their own means of ensuring maternal survival. In Ondo, a state in southwest Nigeria, the government linked persistently high rates of maternal death to a protracted process of secularization and created legislation to condemn birth in mission homes as an act that was "too religious." This contemporary conflict occurs in the setting of two coinciding developments: a dramatic expansion and transformation of Pentecostal Christianity in the 1980s on one hand and an increase in global humanitarian concern for rates of maternal mortality on the other hand. Based on several years of fieldwork, *To Be Delivered* is a sustained historical and ethnographic study of the lived experiences of Nigerian women seeking pregnancy care under a government bent on modernizing through secularization.

I mobilize conceptual tools provided by medical anthropology, secular studies, African studies, comparative literature, and critical race studies as I examine Nigeria's problem of maternal mortality. I approach secularism, not as the neutral space left when religion is removed, but as a pattern of political rule that necessarily intervenes on the religious. If modernity is a project, secularism entails the specific construction and distinction of categories of "the secular" and "the religious" that purportedly nonmodern people must strive toward. In Ondo, a woman's

reproductive body is configured as a public space that the state seeks to sequester from what it deems to be "too religious." In tracking this national project of creating and sustaining a modern state through the intimate realm of lived experience, I ask: how are secular bodies made? What are the specific disciplining techniques and practices that attempt to render the religious body secular, and the forms of resistance and conflict they come up against? I attend to the cultivation of dispositions to understand how distinctions between "the religious" and "the secular" are constituted and undermined from intimate to national realms by studying how Nigerian women, their caregivers, and government officials enact their understandings of and assumptions underlying this binary as it relates to maternal health. Paying specific attention to the role of gender in state-building projects as women are routinely framed as indicators of success, I show how women's bodies and reproductive processes are a contested site for postcolonial states aspiring to what international funding and governing agencies construe as modern. Mission homes and the women who seek care in them call for renewed thinking around African women in relation to the project of secular modernity.

Table of Contents

Introduction
Is Maternal Mortality a Problem?

In March of 2016, I drove three hours from Akure to Ibadan in order to present my early research findings to the Department of Archaeology and Anthropology at the University of Ibadan. I had concluded a year of ethnographic research exploring experiences of pregnancy and childbirth, and I was humbled by the prospect of sharing my project with anthropologists from Nigeria's most prestigious institution of higher learning.

Over the previous six years, I had followed the development of Ondo state's maternal health campaign and the experiences of the pregnant women who are its targets. During three trips to Nigeria, I accompanied women as they navigated the complex system of Ondo's state programs, biomedical hospitals, Pentecostal churches, and all of the other undocumented, intimate settings in which they manage their pregnancies and eventually give birth. Contextualizing these experiences, I attended state government meetings with representatives from non-governmental organizations and international development agencies. I interviewed government officials, hospital directors, and members of the state primary care development board along with dozens of doctors, nurses, and informal care providers. To appreciate the stakes of religious engagement for Pentecostal women involved in faith healing, I visited birth attendant training sites for both the Redeemed Christian Church of God (RCCG) and Christ Apostolic Church (CAC) and attended RCCG's annual convention at the Redemption Camp in Ogun state in 2014 and 2015. Finally, to appreciate the larger historical context of humanitarian attitudes toward African women, I carried out archival research at the World Health Organization, focusing intently on the history of the Safe Motherhood movement.

Having left my field site that morning, my remarks were mostly descriptive. I described how women in Ondo, a state in southwestern Nigeria, sought out and received prenatal care and delivered their babies with particular focus on births in *mission homes*. I explained how these spaces, run by Pentecostal churches, are not new, dating back to the advent of Pentecostalism in Nigeria in the early 20th century, but have only recently become a subject of state interest. In them, pregnant women attend weekly prayer meetings, where embodied devotional practices of singing, dancing, speaking in tongues, and drinking sanctified water are performed in order to bring about successful deliveries. As the state of Ondo embarked on an aggressive public health campaign to respond to reports that found Ondo to have the highest maternal mortality ratio in the southwestern region in 2008, the state began to frame mission homes and their ambivalence toward biomedicine as the biggest impediment to its progress. Confident with this assessment of the situation, in 2014, Ondo banned birth outside of state hospitals and began investigating maternal deaths with the intent of arresting the birth attendants found responsible. Even so, this did little to deter women from seeking care in mission homes. In my presentation, I had taken great pains to avoid making any definitive claims with one admitted exception. I concluded my presentation by suggesting that taking "the religious" seriously could tell us something new about the so far intractable problem of maternal death in Nigeria.

In other circles—with physicians in Ondo's maternal health program or public health professionals in northern California, for example—this idea is often met with some version of a question that supposes I must have missed what was really going on, the actual reason women delivered in mission homes. The suggestion I often get is that mission homes are simply a response to state inadequacies and that if I asked the right questions I would find that their popularity could be explained by socioeconomic indicators. Were the women not too

impoverished to afford to deliver in hospitals? Too far away? Too uneducated? Too marginalized? Too disempowered? This form of reasoning enacts a secular logic—religious beliefs are treated as indicators of underlying ("real") political economic causes. Thus, they intrinsically link modernization to the replacement of religious faith with scientific reasoning and secularization is their hallmark of modernity. This binary conception of the "the religious" and "the secular" has been interrogated in recent decades by the work of anthropologist Talal Asad (2003) in particular. And even though much scholarly inquiry has been successful in complicating the role of religion in the modern world by exposing religion's relevance in the public sphere (Cassanova 1994), secularism's roots in Latin Christendom (Taylor 2007), the specific contributions of Protestant missionaries (Keane 2006), and the enchantments of modern technologies (Modern 2011), secularization narratives still occupy a mythic status in the modern liberal public imaginary.

The secular is so woven into liberal common sense that it is hard to discern. Secularity is taken for granted as the absence of religion, a standpoint that exists outside of religious discourse and thus can arbitrate them fairly. But Asad posits that nothing is essentially religious. It is the secular—a set of specific norms, orientations, behaviors, and sensibilities that can be traced back to Western European Christian origins—that produced the modern category of religion as centered on individual belief within a private sphere away from the public and the political. As such, I merely use the term "religion" for the sake of efficiency. We can better understand the secular, not as neutral or empty of religion, but as engendering the very political and social arrangements that determine the contours of what is considered to be religious practice. The dismissal of religious practice, then, a defining characteristic of secularism is simultaneously its recognition. Further, presuming that "religion" has no role in the public sphere in contrast to

"biomedicine[1]" obscures how biomedicine has been "integral to the secular project of making invisible the religious affects and sensibilities of the modern political/biological individual" (Whitmarsh and Roberts 2016).

My contention that we might better understand experiences of pregnancy in Nigeria by thinking with the religious commitments of Nigerian women also follows from Saba Mahmood's work on the way practices of piety among Egyptian Muslim women reveal a critique of Western feminist understandings of agency (Mahmood 2005). My work builds on her practice-centered ethnography by attending to how Nigerian Pentecostal women live out their religious sensibilities through reproductive practices and the resultant dispositions toward birth, death, and risk that structure them.

It is not to say that religious innovation occurs in a vacuum outside of social and historical conditions. Conversion, for example, can be examined convincingly through the lens of a variety of interrelated formations that are particular to place, time, and relations of power. Rather, I argue that because we can find aspects of the religious in the secular, it is equally important to understand, as Asad puts it, "secular conversion into modern ways of being" (Asad 1996, 263). Taking religion seriously, as I suggest, then actually entails taking secularity seriously. Scholars and policy makers, who deploy reductive explanations for the continued prevalence of religious experience—a deceptive salve for economic or political precarity—take the secular for granted in ways that not only mask latent Christian commitments but also obscure the modernizing tendencies of religious practice.

[1] I take biomedicine to be both the science and practice of medicine based on biological principles and the conceptual frameworks that give it power. I choose not to use the term "Western medicine" because that term privileges the West's contributions to biomedicine, whereas much of biomedicine is dependent on research and revelations made throughout the world.

To privilege the political economic above all else reduces the richness of lived experience to a set of mechanistic calculations, which leaves out the senses, emotion, affect, desire, aesthetics. These are the calculations of a "rational" subject and any deviation, religious or otherwise, is "irrational," a manifestation of false consciousness. This move denies the religious subject of the empowerment automatically attributed to a purportedly secular subject. In this framework, a common critique holds that Nigerian women who deliver in mission homes are either duped by their pastors into believing in the power of faith healing or victims of a capitalistic, patriarchal society that denies them the means of accessing "safer" (read: biomedical) methods of childbirth. By contrast, an American woman who delivers at home is often conceived as exercising her choice to do so, asserting her knowledge of her own body in the face of an oppressive, male-dominated biomedical regime. Paying attention to who is understood as wielding informed decision about their reproductive health reveals a great deal about assumptions concerning race, ethnicity, gender, geography and religious identity, which shape notions of modern political belonging. For this reason, the complex lives of Nigerian women deserve sincere engagement.

*

I chose Ondo as the site of my fieldwork because it poses an exemplary challenge to the secular in ways that allow for this type of engagement. Ondo is a state in southwestern Nigeria with a population of nearly 3.5 million people who are predominantly Christian and identify ethnically as Yorùbá.[2] Ondo was established in 1976 by military ruler General Murtala Mohammed in

[2] Yorùbá is an ethnic and linguistic descriptor of people sharing common ancestry in West Africa but also divided into over 200 subgroups distinguished by dialect and cultural practice. With few exceptions, I limit my cultural analysis in this dissertation to Yorùbáland, an area that corresponds with southwestern Nigeria, Togo and Benin as the setting of my research, Ondo state, is in Yorùbáland and still primarily populated by Yorùbá people. There are, however, many cosmological and mythological resonances with neighboring ethnic groups, including the Igbo (Ogunyemi 1996).

response to sub-ethnic group agitations for resource control and self-determination in the setting of newfound oil wealth (Watts 2004) and was later cut down to its current size when the state of Ekiti was carved out of its northern end in 1996 following twenty years of sustained struggle by Ekiti Yorùbá. Forming the eastern boundary of Yorùbáland, Ondo shares characteristics with both the oil-rich Niger Delta region (accounting for 12% of the country's crude oil) and the largely agricultural southwest (as largest cocoa producing state in the country). These resources among others have allowed Ondo to enjoy an economy that outperforms a majority of the other Nigerian states. However, what made Ondo particularly interesting for this project are its intersecting religious and medical landscapes. The challenge Ondo poses for the myth of secularization stems from the parallel development of both an extensive biomedical maternal health care program and highly organized networks of informal faith-based birthing centers including mission homes. Ondo is both one of few states to provide free health care to pregnant women and an important historical site for faith healing and Pentecostalism in Nigeria.

Among the states that offer free maternal health care, Ondo's commitment to lowering maternal mortality is uniquely comprehensive despite regional disparities within the state.[3] My research spans across the population-dense state capital of Akure to the semi-urban centers and rural farmlands of Odigbo, a government district in the southern region of the state and also follows sociohistorical traces to important Pentecostal sites in the nearby states of Kwara, Osun, and Lagos. As it is the capital of Ondo, Akure houses most government administrative buildings and several tertiary technical educational institutions including the Federal University of Technology, Akure, Federal College of Agriculture, School of Nursing and Midwifery. Akure is

[3] As of 2009, the nine states with free comprehensive maternal and child health care included from the Yorùbá southwest, Osun and Ondo; from the Niger Delta, Bayelsa and Enugu; from the North, Kaduna, Nasarawa, Taraba, and Adamawa; and Abuja, the federal capital territory (Okonofua 2011).

also the center of economic activity for the state with several regional markets, supermarkets, and a new commercial mall, which opened in 2015 to much fanfare while I was there. Akure has two major tertiary government hospitals (Mother and Child Hospital-Akure and State Specialist Hospital) along with several smaller primary health care centers, private hospitals, mission homes, and spiritual healing centers. Odigbo, a three-hour drive south of Akure on a single lane paved road, is comparatively resource-limited. Though it has a sizable agricultural economy, when I arrived the residents had been without access to public utilities, including electricity, for over a year and were dependent on bore holes for water. Odigbo is home to several primary and secondary health care centers and two general hospitals, along with numerous private practices and a robust association of indigenous healers. The closest tertiary government health center, Mother and Child-Ondo is an hour and half north in Ondo town.

The government, under the leadership of the then newly elected physician-governor Dr. Olusegun Mimiko, introduced a health program in 2009 in order to make progress toward the fifth millennium development goals, one of which was to decrease maternal mortality rates by 75% between 1990 and 2015. The governor's plan, *Abiye* (or "Safe Motherhood" as it is translated), comprised a complete revamping of the state's maternal health care programming, including the recruitment of health care professions, construction of hospitals, renovation of primary health centers, and acquisition of ambulances (Oladeru 2012). Applauded and funded by the World bank (as well as subsequently the Ford Foundation and the Bill and Melinda Gate Foundation), *Abiye* commissioned the construction of the two Mother and Child Hospitals mentioned above. All aspects of health care for pregnant women, from prenatal vitamins to Cesarean sections, was intended to be free. Although in practice, Ondo government health

centers did not entirely live up to the *Abiye*'s original intentions, health care on average was made much less expensive than even informal alternatives like mission homes.

Nonetheless, informal birth attendants thrive in Ondo. While the term *traditional birth attendant (TBA)* is more commonly used in global health communities (the UN defines it as a person who assists mothers during childbirth and acquired her skills by delivering babies herself or through apprenticeship to other TBAs), the qualifier "traditional" is both ambiguous and imprecise. As indigenous religions are supplanted by Christianity and Islam, what might have been considered "traditional" (herbalists and diviners, for example) has become less distinct from other faith-based practices of world religions. Additionally, "traditional" is ambiguous in that it could variously denote a broad set of practices: for example, those originating in a precolonial period, those that are non-biomedical, those that are faith-based, or those that are paced down intergenerationally. For these reasons, in my discussions, *informal birth attendant* will be used to refer to all unlicensed providers who care for women during pregnancy and delivery without formal education and training. Informal birth attendants may include: birth attendants who are trained in church maternity schools and use mostly prayer to aid in delivery in the setting of a mission homes (church birth attendants or faith-based birth attendants); those who work as apprentices in private hospitals until they feel confident enough to open up their own clinics; and those who practice with herbalist knowledge passed down through generations. Often, the distinction between these different types is not straightforward and many providers have a multifaceted set of techniques and belief systems that they use to care for their clients. Church birth attendants, however, are unique among informal birth attendants in their insistence that "Prayer is the best medicine." Yet, more and more, Pentecostalism and effective prayer seem to penetrate all forms of care in Ondo. Even as *Abiye* program officials attempt to prohibit birth

in mission homes, their secular efforts are necessarily imbued with the religious. As I show, it is not that Pentecostal mission homes are religious, it is that they are *too* religious or religious in the wrong way that creates problems for the state.

*

Pentecostalism is a rapidly growing global movement, which takes as its origin the Azusa Street Revival led by Willian J. Seymore, a student of Holiness preacher Charles Parham, in Los Angeles in 1906. It's transformation and unrelenting global spread over the past several decades have prompted scholarly examinations that emphasize globalization (Robbins 2004; Meyer 2010), mass media technology (Hackett 1998; Meyer 2007; Marshall-Fratani 1998), prosperity and neoliberal capitalism (Meyer 2007; Comaroff 2009), spiritual warfare (Meyer 1999), and political participation (Marshall 2009). Many of the characteristics scholars associate with Pentecostalism—faith healing, prophecy, exorcism, speaking in tongues, spontaneous prayer, exuberant liturgical expression—were found in religious movements in Nigeria as early as the 1910s. As Holiness and Pentecostal literature[4] from Europe and America became more readily available in Nigeria, indigenous church groups made contact with British and American Pentecostal churches, bringing Pentecostalism officially to Nigeria in the 1930s. These early churches fall under the broader umbrella of African Independent Churches or AICs (where the "I" alternatively stands for Indigenous, Initiated or Instituted): churches led by Africans that broke away from European missions. One set of AICs emerged in Nigeria out of the *Aladura* movement. The *Aladura* movement was an indigenous prophetic-healing movement that spawned the *Aladura* churches, which include Christ Apostolic Church (CAC) and Cherubim

[4] Including the writings of Kenneth Hagin, Oral Roberts, Robert Tilton, Kenneth Copeland among others.

and Seraphim (C&S), among others. CAC is considered to be the first Nigerian Pentecostal church by many and I refer to them as Pentecostal in my work.[5]

Much of the study of Pentecostal churches has involved classification. This first set of Nigerian Pentecostal churches established between 1930 and 1960 are categorized as classical Pentecostalist and also includes an early version of the RCCG. These churches have been further classified in different ways (see for example, Gaiya 2002). While doctrinal details vary, the overarching emphasis on effective prayer, visionary guidance, and the charismatic gifts of the Holy Spirit, primarily speaking in tongues and faith healing, remains the same. Classical Pentecostal churches are also notable for their liturgical spontaneity and indigenously styled music. An intensely prayerful life is held in high esteem by classical Pentecostals who abide by a Puritanical ethic and retreat from material pursuits.

In the 1970s, a new form of Pentecostalism emerged that is referred to as neo-Pentecostalism or Charismatic Pentecostalism and considered a "religion of modernity itself" in the way it "mediates, negotiates and mitigates modernity" (Van Dijk 2000, 6). Neo-Pentecostalism is a global movement. In Nigeria, it became popular among students and young educators on university campuses. The University of Ibadan and University of Ile-Ife (now Obafemi Awolowo University) were major centers of activity in this regard. The churches that formed during this time include William Kumuyi's Deeper Life Bible Church and David

[5] Whether the *Aladura* churches should rightfully be called *Aladura* Pentecostal churches has sparked some debate, but given the historical affiliations with European and American Pentecostal churches, dogmatic similarities, and the fact that church leaders consider themselves to be Pentecostal (Peel 1968a, 48; Crumbley 2008, 40), I see no reason to categorize them otherwise. Although perhaps useful for the purposes of comparison and even analysis, I see this need to classify and discern as itself a "secular" act. In an attempt to create some distance from the assumptions that underlie religious categorization, I focus instead (especially in Chapter Two) on practices as they have evolved over time and circumstances that provide the context for this evolution. In fact, the church members that I came in contact with myself were more concerned with what I did—whether I went to church regularly, prayed daily, and put my faith in Jesus as my one and only savior—than what I called myself.

Oyedepo's Living Faith Church Worldwide (also known as Winner's Chapel). Unlike their classical Pentecostal predecessors, neo-Pentecostal churches do not hold their members to strict ascetic standards. Members, often university-educated and from middle and upper-classes, wear flashy outfits and jewelry to church and though alcohol is frowned upon, it is not forbidden. Another contrast is that women can be found in formal leadership roles in many neo-Pentecostal churches. Nigerian neo-Pentecostalism embodies many of the characteristic of the global Pentecostal movement, marked by the promise of material salvation ("health and wealth") under the condition of becoming "born again" and new techniques of mass communication. Though at the time of its establishment RCCG could be best classified as classical Pentecostal, the church underwent a transformation when its leadership changed in 1980 inspired by the neo-Pentecostal movement of the time. Adopting a new global orientation and a strategy of rapid expansion, RCCG is now at the forefront of Nigerian Pentecostalism. It has grown rapidly and can be found in an estimated 196 countries and twenty-five states in the United States. Church leaders of both sexes often hold other jobs; lawyers, engineers, and even physicians are commonly found in RCCG congregations (Ukah 2003).

All of these churches and many more are found in overwhelming numbers in Ondo state. On one slow twenty-minute walk in Akure, I counted fourteen distinct churches, and during a five-minute taxi ride later that day, I noted twenty-six more. Most of them were Pentecostal while those that were not had clearly adopted charismatic features, a phenomenon that Joel Robbins (2004) traces back to the 1960s when mainline Protestant churches were compelled by their members to emphasize the gifts of the Holy Spirit.

Part of the success of Pentecostal evangelism has been attributed to their ability to incorporate local religious traditions, competing Gods for example, into their own by marking

them as manifestations of the devil (Casanova 2001; Robbins 2004). Birgit Meyer (2012) considers spirits in Ghana in order to call into question the association between disenchantment and secularization. She rejects a view of modernity as disenchanted, opposed to some past or distant "*still* enchanted" cultures and finds that the Pentecostal engagement with spiritual warfare has the effect of keeping the world enchanted. Jean Comaroff similarly argues, "These days, the life of the spirit extends ever more tangibly to profane realms beyond the space of the sanctuary and the time of worship, heralding a significant reorganization of the modernist social order as a whole" (Comaroff 2009, 20). In Nigeria, I find that Pentecostalism as it is practiced renews (while also reconfiguring) Yorùbá religious conceptions of the world, which are not organized around the distinction between material and spiritual, practice and belief. Nigerian women's reproductive practices are simultaneously demonstrations of their faith.

Notably, Pentecostalism, with its ecstatic forms of worship, engagement in mass media campaigns, and celebration of health and wealth, has also entered into discussions of the role of religion in the public sphere. Meyer argues that even in the colonial world, "a modern site par excellence," it was impossible to prevent Christianity from being "disturbingly public" (Meyer 2004, 464). Further, she writes,

> The important and marked public role of [Pentecostal-Charismatic Churches] testifies to the fact that the master narrative of secularization, which claims an intrinsic link between modernization and the decline of the public importance of religion, is inadequate to understand PCCs' attraction and impact on the political as well as personal level (Meyer 2004, 466).

Meyers contends that Pentecostal churches accomplish what African nation-states have been unable to do in the midst of wars and poverty. She argues that due to the "precarious role of the

African postcolonial state" (Meyers 2004, 465), Pentecostal churches play an increasingly significant role in the imagination of communities, binding citizens to a vision of the nation. Comaroff also notes that "[Pentecostal] movements are assuming a widening array of civic responsibilities, especially where state sovereignty has been compromised for one reason or another" (Comaroff 2009, 21).

While I appreciate their exploration of the ways that Pentecostalism disrupts narratives of secularization, my own research is less concerned with narratives of failed states. In posing Pentecostal birthing practices as a challenge to the myth of secularization, I am interested in how church and state become entangled. Rather than filling gaps left open by the state, mission homes in Ondo continue to remain relevant despite expansive state maternal health infrastructure. I focus on CAC and RCCG as they are archetypal representations of classical Pentecostalism and neo-Pentecostalism, respectively. The two churches are well-known for their networks of mission homes. Unlike other Pentecostal churches that may offer services to pregnant women, both CAC and RCCG are highly organized and have established training centers where birth attendants are taught the practice of delivering babies. Both churches stress their ability to provide reproductive solutions for women as core components of their doctrine. But, as my research demonstrates, their relationships to biomedicine are very different and consequently so are their relationships to the state.

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Pentecostal mission homes and the Ondo state government come into conflict around the question of maternal health against the backdrop of a long history of the status of women serving as a marker of progress. As Barber Conable, former president of the World Bank, noted at the first international Safe Motherhood conference in Nairobi, "maternal health care…is an

investment in development" (Conable 1987, 155). This history extends to the colonial period, a time when Protestant and Catholic missionaries, operating in conjunction with colonial administrators, targeted women and their reproductive functions in efforts to "civilize"—an earlier iteration of development. Articulation of women and reproduction with state and development has been a subject of anthropological concern for several decades now. This is especially the case in studies of Africa (although much has been written in other contexts as well[6]). Megan Vaughan's work shows how colonial medical discourse on Africa, though not monolithic, was sexualized, gendered, and racialized in ways that drove colonial intervention and placed women at the center of these interventions (Vaughan 1991). Biomedicine was intrinsic to the operation of colonial power. Vaughan discusses how maternal and child welfare became a chief concern among medical missionaries, which would later inspire colonial government health priorities. Recognizing the significance of childbirth, Christian medical missions turned their medical and missionary efforts toward women and children. They understood midwifery and childcare to be a locus for social reproduction. Accordingly, midwives were thought to hold a certain moral authority in their communities. Reforming childbirth and childcare would be the most expedient way of reforming the African mind and bring about new subjectivities.

Nancy Rose Hunt positions childbirth as a site of struggles of power in what is now the Democratic Republic of Congo. She explores "why medicalized motherhood and childbearing become so prominent an agenda in the Belgian Congo" (Hunt 1999, 5), and finds that drastic depopulation and infertility heightened Belgian concern with maternal health. While colonial officials attributed the high rates of mortality and low birth rates to prostitution and immorality

[6] See Faye Ginsburg and Rayna Rapp's edited volume, *Conceiving the New World Order: The Global Politics of Reproduction* (1995) and Sarah Pinto's *Where There Is No Midwife: Birth and Loss in Rural India* (2008) for example.

in urban centers, Hunt's work exposes the colonial violence at the root of population decline. In 1920s Congo, colonial officials were disturbed by African practices of birth spacing and rather than believe that African could abstain from sexual intercourse for up to three years between births, colonial functionaries were convinced that Africans were committing infanticide. Within this colonial framework, "motherhood was redefined" in order to "conserve human capital" (Hunt 1999, 164), and childrearing became a national as well as moral duty. Missionaries were central to shifting conceptions of motherhood, encouraging domesticity and monogamy, which they thought would encourage population growth. This process was also mediated by Congolese midwives, teachers, and nurses, "colonial middle figures" who worked at the intersection of colonial and medical control.

While I draw from careful analyses of care, political economic critiques of medicine and medicalization, and work on the politics of reproduction like those of Vaughan and Hunt, I find that the analytic of the secular has been missing. While they interrogate how biomedicine fosters a specific form of Protestant religiosity, they pay less attention to "how the work of constructing political secularity has itself been achieved through medicine" (Whitmarsh and Roberts 2016, 204). Lucinda Ramberg's *Given to the Goddess* (2014) is helpful for beginning this conversation. She sheds light on the practice of wearing matted locks (jade) as sign of devotion in a South Indian devi (goddess) cult and the state and NGO biomedical efforts to reform it. Following Asad, Ramberg takes modernity to be a rationalizing, secularizing, civilizing, and progressive project. Categories of sexual and religious personhood come to specify who does and who does not qualify as secular and modern. Devadasi dedications are categorized as forms of illicit sex and superstition, delineated from the normative categories of kinship and religion and thus not admissible to the rights and protections of citizenship, which she defines in its broad sense of

positive state recognition. In this way, the state decides what counts as true and false religion and proper and improper sexual activity. Ramberg argues that these government-sponsored campaigns, which take the form of cutting jade and distributing shampoo, are attempts to remake the body as a fit site and sign of modernity. It is a "story about what kind of work the body is made to do to become modern" (Ramberg 2014, 13). In Ondo's attempts to portray itself as worthy of international aid through secularization, the woman's reproductive body is also configured as a public space that religion is not allowed to take part in. In my research, I track the national project of creating and sustaining a modern state through the intimate realm of lived experience. I pay specific attention to the role of gender in state-building projects as women serve as indicators of success. I show how women's bodies and reproductive processes are a contested site for postcolonial states aspiring to be seen as modern, which has less to do with an concrete notion of what it means to be modern and more to do with access to the global flows of money and power. A diverse assemblage of biomedical institutions, NGOs, hospitals, and funding agencies work in concert in ways that make clear what are recognizable forms of religion and therefore, what warrants recognition and protection. However, Pentecostalism's engagement with the modern tells a different story than Ramberg finds in India, one in which the religious cannot so easily be equated to the traditional.

Hunt's attention to discourses about motherhood in her study of childbirth is also important for this conversation. Work on reproduction among Yorùbá women in southwest Nigeria emphasizes the importance of understandings of fertility and motherhood in Yorùbá communities and the culturally specific meanings and values attached to the female body, sexuality, and reproduction (Pearce 1995; Adetunji 1996; Renne 2002). Ideas about motherhood bear on how we think about pregnancy, childbirth, and even reproduction. I choose to study the

problem of maternal mortality and the reproductive experience of Nigerian women through the analytic of motherhood because it brings together several overlapping sentiments that are often obscured by biological and even social studies of reproduction. Constructions of motherhood tell us about priorities, desires, beliefs, and fears. It is my intention, following the tradition of black feminisms[7], to rewrite the terms of engagement with African woman. What Nigerian women are experiencing and saying about their own predicaments offers a wealth of insight that I demonstrate is more empirically sound than dominant conceptions of motherhood, for example.

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To close, I return to my presentation at the University of Ibadan mentioned above. At the end of my talk, I braced myself for the usual response to my emphasis on religion as a way of gaining insight on the problem of maternal mortality.[8] To my surprise, there were no comments of this nature. Instead, an anthropologist in the department responded to my talk, not by suggesting other possible reasons for why women deliver in mission homes, but by questioning the validity of the entire premise of maternal death in Nigeria. He did not think so many women were dying and asserted that maternal mortality was not as big of a problem as the "Western world" made it out to be. He could not understand why they (and I) were so preoccupied with it except maybe to justify their (and my) continued intrusion into Nigerian matters. In preparation for field work, I had read countless studies on pregnancy-related deaths. In every study, Nigeria's situation was presented as particularly dire. Maternal mortality ratio (MMR) estimates range from 500 to 1000 deaths per 100,000 live births, making Nigeria the largest contributor to maternal death

[7] The list is long, but here I am thinking of bell hooks, Alice Walker, and Chikewenye Okonjo Ogunyemi in particular.

[8] World Health Organization defines maternal mortality as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes." (http://www.who.int/healthinfo/statistics/indmaternalmortality/en/)

worldwide (WHO 2015; NDHS 2014). The lifetime risk of death due to a maternal cause is estimated at 1 in 22 (WHO 2015). Or formulated another way, one woman dies every 10 minutes from causes related to pregnancy or childbirth. Still, the Nigerian anthropologist in front of me did not see maternal mortality as a problem.

I was not sure what to make of his comment/challenge. My first thought was that one could point out that he is male, as was the majority of the audience, and that perhaps it was beyond his male perspective to consider an issue that only directly affected the lives of the opposite sex. Nigeria, a country where assault on a woman carries a lesser sentence than assault on a man[9] and the constitution tacitly endorses child marriage[10], is undeniably patriarchal. While the historical origins of the current situation of male dominance are less straightforward (a point I discuss further in the next chapter), detrimental "cultural beliefs," which reduce the status of women are often cited as an important reason for high maternal mortality numbers. The view that the University of Ibadan anthropologist espoused might be explained as further validating both the problem and one of its causes. Or stated otherwise, his response confirms what many global health analysts contend is at the root of maternal mortality, a problem of political will: maternal mortality is a problem *in* Nigeria because it is not a problem *for* Nigeria. However, an issue that concerns black women in Africa requires an analysis that takes into account not only gender, but

[9] Section 353 of the Nigerian Criminal Code states that, "Any person who unlawfully and indecently assaults any male person is guilty of a felony, and is liable to imprisonment for three years. The offender cannot be arrested without warrant," while Section 360 of the same Criminal Code is much more lenient: "Any person who unlawfully and indecently assaults a woman or girl is guilty of a misdemeanor, and is liable to imprisonment for two years."

[10] During the summer of 2013, Nigerian senators gathered to consider recommendations made to them by a committee tasked with reviewing the country's Constitution. One of the recommendations referred to situations in which Nigerian citizens can renounce their citizenship. The section in question states that citizens must be of full age to do so. It also specifies both that full ages meant at least eighteen years old with the exception that marred woman could be considered full age. The review committee has original recommended that this later exception be removed and the senate voted in favor of its removal. The vote was, however, over turned when a northern senator argued that it discriminated against Muslim women are considered "of age" upon marriage. While the senate did not exactly legalize child marriage, their decision to retain the controversial clause was considered to be an implicit legitimization of child marriage. The decision, made during my first summer of field work, sparked a contentious public debate marked by the hashtag, #ChildNotBride on social media platforms.

race, imperialism, and the postcolonial concern with Euro-American hegemonic regimes of power and knowledge that I choose to believe my respondent was attempting to bring to light.

In my own response, I found myself resorting, in vain, to my own faith in the scientific method. Maternal mortality, however, is tricky. As Clare Wendland (2016) notes, without reliable civil birth and death registries, which require a robust infrastructure of surveillance, it is impossible to count how many women die for reasons related to their pregnancies. As a result, elaborate statistical modeling is employed with variables that rely heavily on a series of assumptions made by researchers at American and European institutions about what else might correlate with maternal mortality. The percentage of births attended by a "skilled provider" is one of the variables used in these calculations because of their assumed impact on MMR. This category is understood to include only doctors, nurses, midwives, and auxiliary nurses/midwives. I will return again to the issue of "skilled provider" (in Chapter Five), but here I only want to underline that in a country like Nigeria, where nearly two-thirds of deliveries are not attended by someone with any of these classifications, there is the potential for this assumption to skew the MMR. There is an argument for maternal mortality not being as big of a problem as the "Western world" makes it out to be in Nigeria.

After my presentation I drove to Lagos where I joined my extended family for a few weeks before returning to the United States. They welcomed me home from "the bush" (a term Lagosians reserve for just about any other place in Nigeria that is not Lagos with few exceptions) and marveled at my ability to survive the year in Ondo. Was maternal mortality a problem for my cousins in Lagos? On the trans-Atlantic flight home, the question returned to me. It has stayed with me as I have worked through my field notes, interview transcripts, and archival materials. It leaves and then returns in the thick of writing. I am haunted by it not because I have

any doubt that women are dying in childbirth in disproportionately high numbers in Nigeria, but precisely because I have no doubt at all. The premise has been with me since my first global health class as an undergraduate student and all subsequent study since then, my time in Ondo in particular, has only reinforced it. But having been primed to see it, how could I unsee it?

In his essay, "Is there a secular body?" Charles Hirschkind suggests that the difficulty with examining the secular stems from an inability to establish appropriate analytical distance as it is "the water we swim in" (Hirschkind 2011, 634). A pervasive dimension of modern life, the secular evades standard research approaches. In his original call for an anthropology of secularism, Talal Asad states similarly that the secular is "not easy to grasp" and perhaps "best pursued through its shadows" (Asad 2003, 16). Even as I am interested in examining the secularist project of Ondo state, I find myself trapped by the forms of knowledge that have formed me. I relay my critic's comment here because it serves as a reminder of the limits of scientific inquiry, the epistemic hierarchies that order the world, and the efficacy of uncertainty. Is maternal mortality a problem *in* Nigeria? Is maternal mortality a problem *for* Nigeria? My answer to both questions is yes. But the stakes of my project now reflect an imperative to engage Nigerian woman not as objects of study but as theorists of their own lives.

To Be Delivered offers a different perspective from the stories often told about reproduction in Africa. Based on a humanistic anthropological approach and inspired by African feminisms, it engages literature, folklore, and critical theory in order to open up new ways of thinking about women, motherhood, Africa, religion, secularism, and modernity. Understanding why woman deliver their babies in churches requires that we stop seeing faith and reason in opposition and instead rely on new categories of analysis. My critique of secular liberal logic is twofold in this sense. First, I further a growing area of inquiry into how secularity is not devoid

of religion by pointing to how this purported neutrality obscures its entanglements with power, imperialism, race and, of course, religion. I demonstrate this by examining both the state's treatment of mission homes as inherently deadly and experiences of pregnant women in them. Second, I interrogate the hierarchies of power inherent in a secular politics of knowledge. The very notion that there is such a thing as science and such a thing as fiction and they are radically different is an effect of the secular that I wish to unravel. I do not dismiss Nigerian literature as fiction in this sense, and engage the stories written as theory.

In what follows, I begin by laying out the theoretical framework, drawn from Nigerian literature and literary theory, that will inform my study of experiences of pregnancy and delivery care in Nigeria. I explore the many meanings of motherhood that Nigerian woman carry with them as they embark on their pregnancy journeys. Chapter Two provides historical context for the rest of the dissertation by exploring the intersection between maternal health and Yorùbá cosmology in the development of Pentecostalism in Nigeria. Chapter Three traces the evolution of discourse on maternal mortality since its conception as an international problem in the 1980s in order to illuminate how African women feature in development projects. I focus particularly on maternal death narratives used to garner political and economic support. I argue that these narratives too often rely on a "single story," which undermines efforts to reduce maternal mortality.

Chapter Four focuses on three women whose experiences of pregnancy take place in spaces of overlap between a biomedical hospital and a nearby mission home. Engaging theories on belief, faith and Yorùbá religious practice, I show how their efforts to collect care – by registering their pregnancies and receiving care at multiple different sites – are likewise demonstrations of faith. Chapter Five examines local battles over the right to care for pregnant

women with community and religious organizations insisting on continuing to play a role despite government mandates criminalizing them. I discuss state efforts to arbitrate and assimilate mission homes and the implications these confrontations have on the reproductive lives of women.

To conclude, I hope to open space for thinking about progress and development differently. What can salvation tell us about development? Taken together, I intend for the chapters of this dissertation to bring light to everyday and extraordinary lives of Nigerian women as they navigate the uneven terrain of motherhood.

Chapter One
The Meaning of Motherhood

"In the peculiar hierarchy of African households the only rung lower than motherless child is childless mother."
– Taiye Selasi, "The Sex Lives of African Girls" (2011)

"If birth is the core of woman's vernacular condition, the source of her cruel predicament, perhaps privileging birth or a rebirth of the nation can be a maneuverable moment in the discourse to set her free, by turning the notion of birth around on itself."
– Chikwenye Okonjo Ogunyemi, *Africa Wo/Man Palava: The Nigerian Novel by Women* (1996)

"Our reality is not that we are 'neither white nor male,' our reality is that we are both black and female; and it is in the belief that our narratives can be transformational that we begin."
– Abena P. B. Busia "Words Whispered over Voids" (1988)

A Phantom Pregnancy

Yetunde was so visibly pregnant when I first met her that I did not think it would be inappropriate to ask her when she was due. She smiled forgivingly. Although I am Nigerian, I was born in the United States and if my accent, my dress, and my manner of moving through the world had not already revealed this to her, this question surely did. It is almost never appropriate to ask a woman when she is due in Nigeria, but not for the reason I was accustomed to in the United States: the dreaded awkwardness that follows mistaking acute weight gain for gravidity. I soon learned that some Nigerian women keep their due dates to themselves as a form of spiritual protection, to prevent potential malicious eaves-droppers from interfering with their pregnancies. A miscarriage could be the result of the ill wishes of a covertly envious friend or an evil spirit that happened to be paying attention on that day.

"Soon," Yetunde answered, "In Jesus Name."

"Amen." I knew to reply.

Despite this embarrassing introduction, Yetunde welcomed me into her home. I lived in her guest bedroom for several weeks during one of my early research visits to Nigeria. Yetunde

had a degree in accounting and worked as an administrator at a local university. We grew close during the evenings we spent together. When there was electricity, we cooked together as quickly as we could in anticipation of the daily blackouts. When power cut out, we ran grumbling to turn on the generator in the dark, quickly turning it off again if the indicator light let us know the power had returned. Yetunde taught me how to troubleshoot the generator if it failed to produce light, how to wash a sink full of dishes with a few handfuls of water, how to price everything from cars to clothes and, of course, how to pray. On weekends, I went with her on her errands, and on Sundays, we went to her Pentecostal church, a *Mountain of Fire and Miracles* church nearby. I called her, *ìyá mi,* my mother, and she proudly introduced me as her daughter.

As the weeks went by, I grew curious about the pregnancy, which she never mentioned. I wondered aloud where the father was. She told me her husband had traveled. But there were no signs of his presence in her flat. I wondered if she had prenatal appointments to attend. She told me everything was in God's hands. But there were no ultrasound images or prenatal vitamins. I wondered if she was preparing for the baby's arrival. She only laughed. But I had not seen a crib or baby clothes anywhere.

One morning, I waited in Yetunde's car outside of her office as she rushed inside to sign in so she would not be counted late. She had left the engine running with the intention of quickly returning to give me a ride to where I needed to be that morning. The look on her face when she re-entered the car stopped my breath. "My spirit just told me I should tell you something," she said. "I just feel I should tell you." This is what she told me and the thoughts that streamed through my head as I listened: The car outside the building next to my office is my husband's. As we had initially parked, he, too was parking. *But this did not make sense. Was not he not on*

leave, after all? Had he not traveled to his village in Ekiti? If he was back from travel why had he not come home? Why had I not met him? He was the tall man who just entered the building. Did you see him? *No. I had not been paying attention.* He is not on leave. He left me. He left me when the baby did not come on time. *On time?*

Yetunde had been pregnant for much longer than nine months. Though, she would not say exactly how long. Months after her original due date, when she had still not fallen into labor, her husband had asked her to go see a medical doctor, but she refused. She went to church instead and prayed for a safe delivery. This annoyed him even though it had been because of him that she had converted to Christianity. Her own father was Muslim. More time passed and her husband became impatient. He left for another woman, who was either expecting or had recently had a baby. She did not know. Tears hesitated in the corners of her eyes as she told me everyone knew and she knew they talked about her behind her back. With her secret finally revealed, she closed her eyes, allowing the tears to roll down her cheeks.

A couple years later, I was reminded of Yetunde in reading the story of Yejide, the protagonist of Ayobami Adebayo's novel, *Stay With Me* (2018). Yejide, a university-educated entrepreneur, is unable to conceive for four years after getting married to her college sweetheart, Akin. At first the young couple is fiercely in love ("love could do anything" (18)), but the weight of expectation from family, from friends, from each other, is too much. Akin is the eldest son of his family and is expected to produce offspring, to continue the family lineage. This burden is translated into the pressure placed on Yejide to become pregnant. Her unrelenting mother-in-law intervenes frequently, ultimately convincing Akin to take a second wife. With this affront to the middle-class progressive values that Yejide thought she shared with her husband, her quietly mounting anxiety turns into desperation. Yejide seeks out doctors, healers, and prophets in her

quest to become pregnant until, finally, she finds herself at the top of the "Mountain of Jaw-Dropping Miracles" breast-feeding a goat under the instruction of a man known to her as Prophet Josiah. After dancing and singing for hours, she feels herself to be "on the edge of some divine experience." She recalls: "the goat appeared to be a newborn and I believed" (44).

Soon after, Yejide misses her period. She begins to experience morning sickness and then breast tenderness and then abdominal growth and then flickers of the baby moving. All of which convince her she is pregnant. She blissfully tells the world, but months pass and her growing belly stalls. In an attempt to quell Akin's disbelief and her mother-in-law's rising suspicions, she goes to a hospital. There she is told by a doctor, who looks at her with pity, that she is not pregnant. Rather, she is suffering from a psychosomatic condition called pseudocyesis in which she exhibits the signs and symptoms of pregnancy but is not pregnant. Despite a negative pregnancy test and the absence of any indication of a fetus in ultrasound imaging, she is not convinced: "'When I hold my baby in my arms, you will be put to shame, all of you who think I cannot have a child. Even that stupid doctor will be put to shame'" (59). Even after Yejide starts seeing a psychiatrist and her body begins to revert back to normal, she holds on to the possibility of her pregnancy. "Akin, you cannot tell me what I am feeling in my body" (95), she responds when her husband attempts to rid her of what he sees as a delusion.

The parallels between Yetunde and Yejide's stories are hard to miss. Both are vibrant, educated, confident Yorùbá women who have intense desires to have children in a society that places tremendous weight on their ability to do so. Both women become convinced of pregnancies that cannot be substantiated by standard medical tests yet continue to haunt them long after their original due dates. Both find strength and hope in their faith in God in the wake of their marriages coming undone due to their inability to conceive. And much of the

inexpressible—something in between shame, courage, frustration, and release—conveyed in the silences as I sat with Yetunde in her car becomes recognizable in the words of Adebayo's novel. Yejide allows us to see Yetunde as part of a larger epistemic configuration.

The trope in which a woman's world falls apart as a result of her childlessness, whether from infertility or infant death, is extremely common in Nigerian folklore.[11] I note the centrality of this theme to indicate what is at stake for Nigerian women seeking to get pregnant and have children. Infertility is loaded with meaning and provides a lens through which kinship, gender, and cosmology can be examined. Experiences of childlessness in Nigeria are endlessly diverse, but the stories that circulate about the women who are not able to have children are much narrower in scope, helping us to understand the meaning of motherhood in Nigeria, what motherhood signifies to women, family, community, and the nation.

"What is the destiny of the childless woman?"[12]

Stay With Me is the latest in a tradition of Nigerian oral and written texts which present childlessness as a tragedy, what Chikewenye Okonjo Ogunyemi, calls the "syndrome of obligatory motherhood" (1996, 17). It would seem that the importance of having children cannot be over-emphasized. The prayer at every Nigerian wedding is for children. Though it applies to both men and women, male infertility is managed differently. Secret arrangements can be made for an infertile man's brother to impregnate his wife as is revealed in the plotlines of both *Stay With Me* and Nigerian film, *Mother of George*. In the case of female infertility, the public

[11] Ayobami Adebayo's is the most recent in a long line of Nigerian creative works that explore the impact of infertility on a woman's status. Similar plotlines can be found in Flora Nwapa's novel, *Efuru,* (1966); in Buchi Emecheta's *The Joys of Motherhood* (1979), in Ifeoma Okoye's *Behind the Clouds* (2006); in Sefi Atta's *Everything Good Will Come* (2005); in Chimamanda Adichie's *Half of a Yellow Sun* (2006); and in Lola Shoneyin's *The Secret Lives of Baba Segi's Wives* (2010).

[12] From *Africa Wo/man Palava: The Nigerian Novel by Women* (1996): Ogunyemi frames the work of the book by asking, "Why is motherhood so central in [novels by Nigerian women]? What is the destiny of the childless woman? How does the syndrome of obligatory motherhood impact culture, political ideology, and, ultimately, writing?" (17).

visibility of the absence of pregnancy denies women the luxury of the privacy that is afforded men in such covert arrangements. For women, the imperative to have children is moral as much as it is practical. In Flora Nwapa's *Efuru* (1966), the first full-length novel to be written in English by an African woman, when the eponymous protagonist is unable to produce a child with her second husband, community members in her village advise her mother-in-law to find another wife for her son:

> Look for a young girl for your son. He cannot remain childless. His fathers were not childless. So it is not in the family. Your daughter-in-law is good, but she is childless. She is beautiful but we cannot eat beauty. She is wealthy but riches cannot go on errands for us (163).

That Efuru (of noble blood) is good, beautiful, and wealthy (due to her resourcefulness as a trader) cannot make up for inability to have children. Efuru, having lost the one daughter she was able to have in infancy (contributing to the dissolution of her previous marriage), is unable to get pregnant again and thus cannot fulfill her role in her family.

Tola Olu Pearce (1995; 1999) situates these strong pronatalist values in the precolonial sociocultural, economic and spiritual world of the Yorùbá (similar arguments can be made for the Igbo and other Nigerian ethnic groups).[13] She contends that fertility desires "derived from several factors, including religious beliefs and the role of the lineage in family welfare" (1995, 195). While it has been argued that children serve as key participants of the production unit of the household, providing labor for subsistence farming and supporting the material wellbeing of

[13] The plight of infertile women emerges as a significant concern in anthropological texts on the extensively studied cosmology of the Yorùbá. J. D. Y. Peel in *Religious Encounter and the Making of the Yorùbá* finds that "no one was more vulnerable than childless, elderly women" (Peel 2003:92) and Roland Hallgren writes, "woman is either fertile and important or infertile and of no importance whatsoever" in *The Good Things in Life: A Study of the Traditional Religious Culture of the Yorùbá People* (1991).

the family (Caldwell 1977, Adepoju 1977), children are also important for the wellbeing that extends beyond the family to the lineage, what Pearce calls, "group immortality" (Pearce 1999, 72). When community members remind Efuru's mother that "riches cannot go on errands for us" (Nwapa 1966, 163), they imply that the bonds between children and their parents afford something more: care that remains after death, including a proper burial. Ancestors, having the power to intervene in the world and even be reborn into the world, are shown respect by ensuring the continuation of the lineage. Conversely, they can show their disapproval of an individual's actions by not allowing a lineage to continue. Children are both sides of an exchange, both payment and reward.

Thus motherhood is vital to the fulfillment of kinship, religious, political, and economic obligations to the family. Having children therefore becomes the concern of the extended family and the community, and not only primarily that of the couple. As Pearce concludes, "social control over women's reproductive functions is thus not new" (Pearce 1995, 198). The long list of taboos that a Yorùbá pregnant woman must adhere to speak to reproduction as a social concern.[14] Yet motherhood is not only about lineage and the welfare of the family. It also becomes intertwined with concepts of personhood. To her neighbors, Efuru is "a man since she could not reproduce" (Nwapa 1966, 124). Motherhood is a necessary requirement for womanhood, an essential stage in the development of the complete female person. It confers status. As such a woman's worth is tied to her ability to produce children. Even in the contemporary moment, this perception of motherhood as the primary source of status for women has influence. Enitan, the hero of Sefi Atta's *Everything Good Will Come* posits,

[14] See Adetunji 1996.

> Better to be ugly, to be crippled, to be a thief even, than to be barren. We had both been raised to believe that our greatest days would be: the birth of our first child, our wedding and graduation days in that order…a woman had to have a child (Atta 2005, 99–100).

The poor treatment of childless women and its devastating effects—psychological suffering, stigma, rejection, and poverty—continues to be a concern of social scientific study.[15]

Creative Motherhood and African Feminisms

The social investment in motherhood should not, however, overshadow its potential for personal fulfillment. In her article on black women's resistance through writing, Abena Busia while recognizing the "tyranny of the necessity to bear children" (Busia 1988, 9), maintains that for most African women the place of mothering is central. Working her way through an impressive array of texts written by black women (both African and African diasporic), she demonstrates how "motherhood is not centrally represented as necessarily antithetical to autonomy, as it has become in much of Western discourse" (Busia 1988, 10).

Often the childless woman of Nigerian novels is also motherless. Her desires for motherhood are made all the more intense by the absence of her own mother. Motherhood fills this psychic lack. For Yejide, an only child who lost her own mother as an infant (an instance of maternal mortality), motherhood is a second chance at the unconditional bond between mothers and children. This immutable love is contrasted with the contingency of the romantic love between Yejide and her husband. Yejide recalls her father telling her that family is about having people who look for you if you get kidnapped. This is how he jokingly justified his polygamy: "He was doing his best to build an army in case one of us did get kidnapped" (Adebayo 2018,

[15] See Marcia Inhorn's special issue on "the cross-cultural dilemma of infertility" in *Social Science and Medicine* (1994: 459) and edited volume, *Infertility Around the Globe* (2012). For studies highlighting mistreat of infertile women in Nigeria, see Ademola (1982), Okonofua et al (1997), Koster-Oyekan (1999) Boerma and Mgalla (2002), Hollos (2003), Dimka and Dein (2013).

65). With both her parents gone and having been rejected by her stepmothers, Yejide feels that only a child of her own can fill this need:

> I had no father, no mother, and no sibling…These days I tell myself that is why I stretched to accommodate every new level of indignity, so that I could have someone who would look for me if I went missing (Adebayo 2018, 70).

Yejide is concerned with her own spiritual and emotional wellbeing. She asks "who will look for *me*?" while Efuru's neighbors ask, "who will run errands for *us*?"

Efuru, similarly having lost her mother, yearns to be a mother. But after two failed marriages, she ultimately finds both solace and power in her relationship with Uhamiri, the water goddess of the lake in her village. Uhamiri is a fictionalized version of the mythic *mammywata*, a figure born from the colonial era transformation of indigenous Nigerian water deities[16] worshipped for their ability to ensure fertility, health, and wealth. Uhamiri, like the figuration of mammywata, is beautiful, wealthy, independent, and though she is childless, she is the symbol of motherhood. In her reading of ***Efuru***, Ogunyemi argues that in her turn to Uhamiri, Efuru "unleashes the secrets of a *creative motherhood*, a creative life" (1996: 153, my emphasis). As Efuru's relationship with Uhamiri intensifies (she becomes a devotee), Efuru continues to prosper economically and socially, transforming into a self-actualized maternal figure, herself, for her community. Summarizing the redemption of the doubly cursed (childless and motherless), Efuru, Ogunyemi writes,

> *Efuru* can be read as a passionate love story between daughters and mothers. Her search to be a mother—that is, a search for the lost self—becomes one with her quest for a

[16] The Yorùbá river mother-goddess, Òṣun is worshipped for her power to make barren women fertile and Odu serves a similar role for the Igbo.

> mother, for wholeness. The joy of motherhood…intersects with the joy of daughterhood (Nwapa 1966, 156).

Importantly, Efuru does not need to reject her motherhood entirely to find herself. In fact it is only through the mythic representation of (creative) motherhood, Uhamiri, that she realizes her inner desires and goes on to "mother" others.

Across Nigerian folklore, motherhood continues to be associated with the divine. Representations of motherhood, fertility, and childbearing are common in the ancient stories of Yorùbá *orișa* or deities.[17] As I will discuss in Chapter Three, many of these strong associations between fertility, water, and personal exchanges with god(s), although somewhat transformed, have significance in contemporary forms of Christianity in Nigeria. When Enitan finally does become pregnant after years of trying, she experiences it as "a presence within me, as infinite as God." (Nwapa 1966, 283) Pregnancy is empowering for her. In her role as creator of life, protector, and nourisher, she approximates the power of God. As a result mothers are seen as deserving of the utmost reverence, at times approaching the levels of exaltation normally reserved for gods or ancestors. One of the most often quoted Yorùbá sayings speaks to this point:

Iya ni wura iye biye

Ti a ko le f'owo ra

[Mothers are priceless gold

That money cannot buy]

These conceptions of motherhood, laden with honor, respect and a power verging on the occult, do not conform to the motherhood that white Euro-American feminist theory poses as oppressive. African feminisms have emerged out of a desire to offer models for countering not

[17] Alternatively glossed as divinity, idol, creator, or God, the significance of the word *orișa* is actually much more complex, evolving over time. See Peel 2003, particularly pgs. 118–121.

only sexism, but racism, colonialism, and imperialism. They operate under the premise that being grounded in African cultural perspectives, they can better respond to the intersection of inequalities that African women face. In their efforts to renegotiate the terms of feminism, African scholars challenged White feminist imposition of Eurocentric ideals and the simultaneous erasure of the experiences of African women. Much of this scholarship originates in Nigeria around the central question of motherhood.

A key contention of this African brand of feminism is that many White feminists, rather than liberating African women, who they pose as victims to African male patriarchy, participate in imposing gender categories that undermine ancient sources of indigenous power for women. In her article, "African Women and Power: Reflections on the Perils of Unwarranted Cosmopolitanism," Mojubaolu Olufunke Okome argues against what she sees as the "pervasive cosmopolitanism that homogenizes and essentializes women's experiences" (Okome 2001, 2). To understand the gender inequalities that exist today in Africa, she argues we should look to missionary and colonial legacies. The colonial enterprise resulted in the separation of public and private spheres and the restriction of women's roles to the latter:

> Where the religion of the colonized had key roles for women to play both as deities and priestesses, the imposition of Christianity ruled these out. Whereas motherhood formerly implied power, it now came to be seen as an encumbrance. Whereas motherhood and participation in the economy were not mutually exclusive, it soon came to be as Africa moved inexorably toward Westernization (Okome 2001, 7).

Rather than alienating women from each other by sentencing them to domestic lives, motherhood fostered relationships between women and allows women the freedom to perform important functions outside of the home. In polygamous Nigerian societies, notwithstanding their issues,

co-wives and other relatives shared in child-rearing, giving women the opportunity to trade and gain economic autonomy in the process.

In her book *Invention of Women* (1997), Oyeronke Oyewumi presents linguistic and religious evidence to suggest that Yorùbá society in precolonial times was gendered differently than it is now. She attributes present gender hierarchies to the arrival of European rule, which displaced some indigenous practices while transforming others. For example, she notes that Yorùbá names and pronouns are not traditionally gendered and suggests that seniority (not gender) was the primary organizing principle of the Yorùbá social world. From her perspective, the present male-dominated sociopolitical landscape is a result of the Western imposition of gender binaries. Oyewumi furthers this examination of how colonial practices and epistemologies have transformed conceptual categories in Yorùbá culture in *What Gender Is Motherhood?* (2016), paying specific attention to the category of *ìyá*. As world religions have gained influence in Nigeria, *ìyá* as a category has been denigrated, losing its "matripotency." Even *Ifá* divination texts, Oyewumi argues, have been interpreted in a way that promotes male superiority. In contrast with Western patriarchal conceptions of motherhood, historically *ìyá* is an honored spiritual category, which implied power and leadership and is without the binary counterpart that exists elsewhere (fatherhood). This meaning is obscured by scholars who propose ahistorical understandings of African society. In her conclusion, Oyewumi asks, "Why is the West, which has pathologized motherhood, and African motherhood even more, our model for liberation or for any kind of transformation?" (2016, 216) This is a question I will return to in Chapter Four as I discuss how global health knowledge practices and discourses around maternal mortality reinforce the very problems they purport to solve.

Motherhood in Nigeria thus has varied, sometimes conflicting, connotations. Ogunyemi argues that the paradoxical meanings stem from a fundamental difference in the treatment of wives and mothers: "While the younger woman writhes in the servility attached to wifehood, the older woman relishes her newfound power over her son's household and community" (1996, 46). Yorùbá mothers have access to the role of *Iyalode* (or *Omunwa*, for the Igbo), a formally recognized political position in which an older woman serves as "mother-at-large," meaningfully supervising her community (1996, 45–46). Countering narratives of maternal domesticity, Yorùbá mothers also serve as *Iyaloja* (mother of the market), managing an economic sphere of life. Ogunyemi's ambition is to show how its power can be harnessed. Though childlessness remains problematic for Nigerian women, she proposes "creative motherhood" as a site of power, accessible to even the childless. Yetunde, who I opened this chapter with, continues to be a mother to me, offering inspiration through text messages even oceans away.

In an earlier watershed article, "Womanism: The Dynamics of the Contemporary Black Female Novel in English" (1985), Ogunyemi lays the theoretical groundwork on which this work is built. Ogunyemi's womanism is reminiscent of Alice Walker's term "womanist." First employed in a footnote to a short story written for Ms. magazine[18], Walker offers a more complete definition in *In Search of Our Mothers' Gardens: Womanist Prose*, Walker's poetic definition of womanist is, in fact, more of a series of free associations. A womanist is: "a black feminist or feminist of color," derived from "womanish," "referring to outrageous, audacious, courageous or *willful* behavior," acting or being "grown-up," "a woman who loves other women, sexually and/or nonsexually," "committed to survival and wholeness of entire people, male *and* female," and "not a separatist, except periodically for health" (1983, xi). The looseness of her

[18] The short story was later published in an edited volume. (See Walker 1980).

elaboration of the term allows her to avoid the pitfalls of white feminism and leaves space for other interpretations.

"[Arriving] at the term independently and …pleasantly surprised to discover that [her] notion of its meaning overlaps with Alice Walker's," Ogunyemi takes up the concept in "Womanism" with more decisive force. A womanist, she offers, "will recognize that, along with her consciousness of sexual issues, she must incorporate racial, cultural, national, economic, and political considerations into her philosophy" (1985, 64). The "peculiar burden" carried by black women, "deprived of her rights by sexist attitudes in the black domestic domain and by Euro-American patriarchy in the public sphere," renders the possibility of an alliance with White feminists "absurd" (1985, 79). Womanism registers a concern that feminist theories of motherhood have been at best insufficient, and at worst, dehumanizing. In line with efforts to decolonize African and African American social formations, and scholarship about them, womanism encourages black women to seek new theoretical models from African sources. By examining the symbolic and political figure of *Iyalode/Omunwa,* Ogunyemi rescues motherhood from white feminism through the concept of the "Public Mother" (1996, 45–47).

Sociologist, Kamene Okonjo (1976) and historian, Lorelle Semley (2012) have both written about the concept of "public mothers" in Nigerian societies. Okonjo finds that the present dearth of women in meaningful political positions is a legacy of the single-sex politics of British colonialism in Nigeria. She describes the Igbo dual-sex system, which predated colonial contact, as comprising two local village monarchs: the male *obi* and the female *omu.* Interestingly, *omu* also means mother in Igbo and comes from *omunwa*, translated as she who bears children. Thus, the term "public mother" is unnecessary in Igbo, as the word for mother already carries the connotation of having a public/political role. Okonjo notes that the *omu* does not derive her

status from her relationship to a king (neither as daughter nor wife). She is chosen on the basis of her age, achievements and resourcefulness. In her fieldwork, Okonjo observed that the *omu* and her cabinet of women councilors settle village disputes, oversee the community market, and represent the women in important collective decisions.

Semley elaborates on the concept of "public motherhood," which she borrows from Ogunyemi, by paying specific attention to the remarkable story of Alaba Ida in the Yorùbá town of Ketu. Alaba Ida served as the important intermediary between the French colonial regime and the town of Ketu (in present Benin) during the early 1900s. In this position, she played an influential role in the formation of the 1906 Anglo-French boundary, ensuring that Ketu would remain under French authority and not become part of neighboring Nigeria controlled by the British. While grounded in empirical detail, her theory of public motherhood is offered to provide a new framework for thinking of the power of women more generally:

> The black feminist and Africanist scholarship does not chronicle a different history of motherhood but sheds light on the depth and breadth of motherhood as experience, institution and discourse (Semley 2012, 610)

In addition to *womanism* and *public motherhood*, other African and Afrodiasporic theorists have developed general frameworks that address concerns emerging from their postcolonial contexts. Molara Ogundipe-Leslie develops the term *stiwanism* from her acronym STIWA (Social Transformation Including Women in Africa) in her book *Re-creating Ourselves: African Woman & Critical Transformations* (1994). Powerfully rooted in the experiences of African women, situwanism, explores indigenous solutions to persistent social problems. Catherine Obianuji Acholonu's *motherism* looks to the rural African women to provide a model for collective empowerment. Motherism, Acholonu asserts, is "committed to the survival of

Mother Earth," its "weapon" being "love, tolerance, service, and mutual cooperation." (Acholonu 1995). Obioma Nnaemeka (2004) proposes *negofeminism* in order to emphasize the importance of inclusion, collaboration, and accommodation, placing the onus on both men and women to improve the conditions of women. Taken together, the African feminisms discussed here offer an important critique of white feminism[19] by reaffirming the transformative power of motherhood while addressing questions of race, class, and imperialism.

Ogunyemi's final thoughts on *Efuru* cap this theoretical exploration of motherhood: "The most important message is a truly Nigerian one: motherhood is not limited to the biological but extends to the social where it better serves woman, gender/politics, and community/nation" (1996, 156). Perhaps this is why my University of Ibadan interlocutor could not see maternal mortality as a problem. In the context of Nigeria, where motherhood is understood as a solution in all of ways Ogunyemi lists, how can he?

I chose to begin with this somewhat long foray into the meanings of motherhood in order to provide theoretical blueprint for what follows. To speak of pregnancy in the African context is to foreground questions of reproduction, population, development, and failed states as population control and failure to decrease the rates of maternal death remain central concerns. Here, I pause to reflect on desire, anxiety, morality, and power in the context of notions and experiences of motherhood to hopefully open up new ways of thinking about maternal mortality, a problem that remains intractable to present solutions posed by the global health industrial complex I draw

[19] There do exist somewhat uneven parallels with White feminism on this issue. For instance, the "Back to Nature" component of the feminist movement.

extensively upon novels by Nigerian women because they demonstrate local approaches to theorizing, narrating, and interrogating the stakes of motherhood.[20]

[20] Following Ogunyemi, Oyewumi, and Okome it is my aim to center the narratives of Nigerian women in my own discussion of their lives. Like Busia, quoted in the epigraph, I believe narratives can be transformational. The quote continues:

> The difference is crucial, for what we are undertaking is a process of affirmation, to proclaim that selfhood, our very own, which has heretofore been "othered." We are not reaffirming our presence or "actualizing" ourselves as if we have been absent, we know we never left; we are simply, but quite radically, reclaiming our own stories, which have for so long been told for us, and been told wrong (Busia 1988, 1).

If anthropology is on one level "a mode of analyzing distinct forms of life through a study of concepts internal to them, embedded and realized in social practice" (Mahmood 2016, 23), these novels help us to do just this.

Chapter Two
Care and Conversion: Legacies of missionary medicine

Sister Ṣola from the Redeemed Christian Church of God (RCCG) maternity center called me late one night, "Baby is coming! Come now!" I had asked her to call me if a woman was in labor no matter what time of day. But even in Ondo's capital, Akure, finding a cab at that hour, past ten, would be difficult if not impossible. I hesitated before calling Dr. Yemi, a young house officer[21] I had met during his obstetrics and gynecology rotation at Mother and Child Hospital (MCH) in Akure, but proceeded because he had a car and had offered to help with my research. As I asked for a ride to the RCCG mission home, I could feel his eyes rolling through the phone, "Fine." Most of the doctors do not understand my interest in mission homes and think studying what goes on in "those death traps" is a waste of time. Better to "phase them out."

Not long after I called, Dr. Yemi's rusted powder blue clunker pulled up outside of the doctor's quarters behind MCH, where I was staying. Having heard its loud exhaust from down the road, I was waiting outside. The ride there was otherwise quiet. A still night. There was not a single car on the road. I tried to thank Dr. Yemi, but he only shrugged. We sat in silence for the rest of the short drive. We arrived at the mission home just after eleven. Both gates of the church compound were locked and guarded by a gateman. While we were being questioned by the gateman, Sister Ṣola came running toward us in her white nurse's cap, an assurance that our presence had been authorized. She held my right hand with both of hers as we walked toward a small cement building across the parking lot from the much larger building where church services were held. Dr. Yemi drove the car into the compound and parked. I had not anticipated

[21] In Nigeria, all medical students spend a mandatory year as house officers after finishing medical school before they can apply for full licensure. This year is roughly equivalent to an intern in the United States medical education system except that house officers remain undifferentiated during this year, rotating through all the specialties of medicine.

what Dr. Yemi would do when we got to the mission home, but was surprised at how relieved I was to see that he would be staying.

Sister Ṣola directed me into the delivery room. We passed an elderly woman and teenage boy sitting on a bench in the entryway on the way in. Inside, a woman lay naked on a black padded table. Her figure was so slight and extremities so delicate that her gravidity seemed absurd. I learned that her name was Taiwo and she was twenty-two years old. Sister Ṣola talked to me while she fluttered about collecting items she would need for the delivery: latex gloves, oil, pads, a few metal scissor-shaped instruments. She works as an assistant to Mrs. Oke, who is the church's birth attendant. The two of them live in rooms on the other end of the building and are on call at all hours of the day and night. Sister Ṣola smiled as she told me that Taiwo had been in school taking an exam when she felt the baby coming. I asked Taiwo what she studied. ("English and Social Studies at [the local university]"). She relayed that she had been taking an exam when she went into labor and then grimaced in pain, turning over to her side to let me know that question time was over. I noticed Mrs. Oke was calmly standing at the foot of the bed, an apron tied at her neck. She told me that Taiwo was fully dilated. The baby would come soon.

"She's my second wife, you know," a deep voice came from the wall beside the door. I had not noticed an older man, likely double Taiwo's age, standing amidst a mountain of baby supplies in the corner. He chuckled, "Thanks for coming, doctor. You made it just in time. I had to drive her straight here from the university." He smiled and his face erupted into a hundred clearly defined wrinkles. He told me his first wife had passed away fourteen years ago after giving birth to triplets—two boys and one girl. The girl had died soon after, but the two boys were alive. One of them was sitting in the entryway with his grandmother. He also had two older kids who lived in Ogun, a neighboring state. He had finally decided to remarry so he that he

could, “leave the kitchen.” By this he meant that he was eager to have a wife who would take over the homemaking chores of cooking and cleaning.

Meanwhile, Dr. Yemi was in the corner, pacing nervously. At that moment, I realized that I had put him in a terribly awkward position. As a house officer, he could not condone what was happening: a delivery with no oxytocin, no IV fluids, no antibiotics, no blood bank, no labs, and no operating room in the vicinity. *What if something went wrong? What would he do?*

Taiwo shifted endlessly on the narrow delivery bed, waiting to be told it was time to push. I watched her closely, anxious she would fall. Finally, after checking Taiwo’s cervix with a gloved hand once again, Mrs. Oke said the time had come. Together, we watched for each contraction. Minute by minute, the muscles in Taiwo’s face, knuckles, and everywhere else alternated between completely tense and wearily slack. Mrs. Oke instructed Taiwo to only push *ti o ba ti mu e* [when it takes you] so that she would only push during contractions. Taiwo, as petite as she was, pushed as hard as she could. Sister Ṣola poured oil over her vaginal opening to foster a smoother exit for the baby. Taiwo’s husband stood at her head, gently urging her to continue pushing. A contraction passed, but Taiwo, still recuperating from the last one, had been unable to push; she seemed at the brink of exhaustion, and I began to feel nervous. My hands clasped together in front of me, I found myself praying for the baby to come.

I let my mind wander to the worst possible scenarios. *What if something did go wrong? What if with such a prolonged labor the fetus was in distress? What if the mission home didn’t allow us to take Taiwo to MCH until it was too late? Would there be enough time to save Taiwo’s life? To save the baby? Would they wonder why Dr. Yemi and I had not brought her to deliver at MCH to begin with? Would Dr. Yemi, still so early in his training, be found guilty of negligence?* As if on cue with my thoughts, Dr. Yemi stood up and started pacing again. At one

point, he paused. He made a move as if he wanted to come over to the delivery table but stopped short of doing so.

*

In many ways the tension felt in this moment—in which a woman attempts to give birth in a church to the horror of a budding physician—had been building for much longer than the hours we spent crowded together in that little room. Religious conversion has long intersected with reproductive health interventions in Africa (Hunt 1999; Vaughn 1991).[22] In recent decades, though, concern about the rapidly increasingly influence of Pentecostalism in all spheres of life including health, has obscured this history. Mission homes in particular are seen as posing a threat to biomedical advancement in Nigeria, with many doctors and public figures blaming them for the high rates of maternal mortality in Nigeria.

This chapter explores the history of the relationship between Christianity and maternal health in Nigeria in order to provide context for contemporary debates on the role of religion in maternal mortality. How did Christianity transition from being considered a harbinger of Western medicine to a detriment to the health of societies? I offer a brief survey of the early-twentieth century introduction of maternal welfare services in Nigeria. I discuss the roles that both missionaries and the colonial government played in the biomedicalization of childbirth in Nigeria. I use the CAC and RCCG as case studies in order to illustrate the importance of childbirth to the development of Pentecostalism in Nigeria. CAC, representative of classical Pentecostalism, and RCCG, now best classified as Charismatic/neo-Pentecostal, both stress their abilities to provide reproductive solutions for women as core components of their doctrine, but their relationships to biomedicine differ dramatically. I argue that not only are contemporary

[22] The British Christian missionary preoccupation with maternal welfare inciting the colonial introduction of biomedicine is well documented (See Arnold 1988; Van Tol 2007).

transformations in religiosity shaping the care of pregnant and birthing women, but reproductive desires have changed how Christianity is practiced in Nigeria. Mission homes are a crucial if neglected site in Nigeria's vast health infrastructure.

Religious change and the biomedicalization of birth

Religious change has been much theorized in the anthropology of religion and Yorùbá people have been central to this conversation.[23] Many have written about the unique role the Yorùbá have had in the transformation and spread of Christian traditions globally (See, for example, Peel 1968; 2003; Ogungbile 1997; 2010) and throughout the African diaspora in particular (Gates 1989; Thompson 1984). This has, at least in part, been attributed to a remarkable tolerance for religious pluralism and innovation in Yorùbá cosmology (Eades 1980). Yorùbá religious traditions—often inaccurately grouped together under the name *Òrìṣà,* the Yorùbá common noun for deity, or *Ifá* after the deity associated with a popular form of divination—are far less unified than commonly described. Although different cults follow familial lineages, in some circumstances, an oracle might be consulted at the birth of child to learn which òrìṣà the child should follow. As a result, variations in traditions between sub-ethnic groups are remarkable, and historically the religious practices or òrìṣà of a conquered people could be adopted by the ruling group. These practices—whether they be sacrifices to win favor from an òrìṣà, offerings made to appease an ancestor, or oracles consulted to predict the future—were woven into daily life in ways that were indistinguishable from other activities that be might be considered to be more "material," tilling soil before planting seeds on a farm, for example. In this sense, the practices of different cults are oriented toward the pragmatics of daily life. J.D.Y. Peel uses the expression "making country fashion," borrowed from the first African

[23] See Peel (1968b) and Horton (1971) among others.

missionary authors in their descriptions of Yorùbá practice, to convey this point:

> The phrase "country fashion," then, serves to blur any sharp division between the religious and the non-religious; it implies a shifting and unbounded body of customary practices rather than a definite and integrated "religion" (2003, 89).

In *Aladura*, Peel (1968a), argues that these characteristics of Yorùbá culture, its dynamism, holistic view of social life, and *this-worldliness,* favored religious innovation and set the stage for conversion to world religions. The specific question of what compels people to give up one religious practice or related belief for another is of course a subject of lively debate. My focus here on the introduction of biomedicine to Nigeria and the related missionary activities is not meant to be an endorsement of neo-functionalist approaches to this question. I am more interested in the conflicts that brought about conversion and the practices that emerged in these conflicts, which later came to shape the boundaries of religious traditions.

The arrival of the Church Missionary Society (CMS) in the mid-nineteenth century marked the advent of biomedicine in Nigeria (Schram 1971). During this time, and for some time after Nigeria was formally established, the scanty British medical service was exclusively preoccupied with tropical epidemics among their ranks.[24] By contrast, Christian missions concerned themselves with the medical care of Nigerians even at the earliest contacts.[25] Initially,

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[24] It was not until 1900 that the Royal Niger Company sold its territories in the Niger delta to Great Britain. Then in 1914, the separate divisions—the Northern and Southern Protectorates and Lagos Colony—were combined to form the Colony and Protectorate of Nigeria under the leadership of Sir Frederick Lugard.

[25] Church Missionary Society exercised considerable influence in the British governance of the Niger Delta region until the First World War. This was evidenced by the attempts made by British trading companies and Governors alike to win their support. In one such instance, not wanting to upset CMS, the Royal Niger Company could do nothing but watch as Graham Wilmot Brooke, a rogue crusader committed to the Christianization of Muslim Africa, joined forces with CMS upon arriving in Nigeria in 1888 and preceded to jeopardize all plans they had for governance of the northern region. Prepared to forgo his British nationality and the protection that this afforded, Brooke forged beyond the area protected by the Royal Niger Company in order to reach those he thought were most in need of conversion. He settled in Lokoja and planned to go further north, but the nature of his mission work – wearing native clothes and declaring that everyone would go to Hell—was met with mounting suspicion and anti-Christian sentiment. The entire expedition ended in the midst of a Fulani Muslim takeover of the region. For more on early missionary expeditions (See Ayandele 2005).

this took the form of campaigns against indigenous medical practice. Converts were barred from seeking medical consultation from indigenous healers and encouraged to heed the medical advice of missionary doctors. However, when other missions arrived (primarily the Roman Catholic Mission in 1885), a missionary scramble to win over souls resulted in more formalized works of charity (Ekechi 1972, 71–73). This deliberate strategy, that of the medical mission, consisted almost exclusively of maternal and child healthcare. Recognizing the symbolic significance of childbirth, missionaries understood midwifery and childcare to be a locus for social reproduction. Reforming childbirth and childcare would be the most expedient way of reforming the African mind and bringing about new subjectivities.[26]

In their rivalry, Protestant and Catholic missions had already established several mission dispensaries, health centers, and hospitals by the time the British expanded their colonial medical services to include the care of Nigerians and the provision of preventive medicine.[27] The British had opened up hospitals and clinics to treat the small expatriate communities, but no effective policy existed to treat Africans.[28] During the interwar period, a significant change in attitudes toward "native health" had occurred. It was at this time that the rates of infant deaths among Nigerians were found to be unacceptably high as indicated in the Annual Medical Reports for Nigeria beginning in the early 1920s. A series of annual health weeks centered on the wellbeing of infants and their mothers in Lagos followed.[29] This was the modest beginning

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[26] In *Curing Their Ills*, Megan Vaughn (1991) discusses how maternal and child welfare became a chief concern among medical missionaries, which would later inspire colonial government health priorities.
[27] The Sacred Heart Hospital in Abeokuta was built in 1895 and later converted into a hospital specializing in maternal and infant welfare in 1926 (Schram 1971).
[28] In fact, Nigeria's governor general, Frederick Lugard, closed a popular dispensary in Lagos in 1913 and cancelled plans for a Lagos maternity in 1914 because he learned that Africans insisted it be staffed by Africans. He vehemently opposed training Africans as even sanitary inspectors, vaccinators, or medical assistants (Gale 1976).
[29] According to the *Nigeria: Report for 1922* (1923), the first "health week" was organized by Lagos town officials in 1922. Prizes were given to the "healthiest babies and the best kept compounds" (1922, 9). These preventive health

of a century-long fixation on population health in Nigeria, which in particular focused on death in relation to childbirth (either the mother or the infant).

Following World War II, British concern for the social welfare of colonized people was formalized into law with the Colonial Development and Welfare (CDW) Act, passed in 1945 (There was also a CDW Act in 1939, but that law produced little effects). The Act required the colonies to produce plans that were balanced between economic development and social welfare. Of note, the British government required the colonial administrations to document the progress of their effort both on economic development and social welfare in ways that foreshadow donor agencies' requirement of measurable progress in Human Development Index metrics in the contemporary postcolonial moment (see Chapter Five).

In general, where medical missions saw their task as healing the body and saving the souls of individuals, British colonial medicine was characterized by large-scale campaigns with goals of improving colonial labor supply and pacifying indigenous populations (Vaughan 1991, Hunt 1999). Yet even after colonial authorities shifted their attention to the health of Nigerians, medical missions remained an influential force. Mission hospitals were responsible for providing training for nurses, doctors, and other medical personnel. Doctors often moved between colonial and missionary health facilities and after WWII the state began funding mission hospitals. Consequently, colonial medical services reflected medical missions around a particular discourse on issues of maternal and child health. The tasks of healing bodies and saving souls were connected. As such, maternal and infant mortality rates were moralized. If individual afflictions signaled a depraved character, population health statistics evidenced societal ills. Health campaigns targeting women and children were attempts to discipline the

weeks continued annually throughout the 1920s. In the mid 1920s, two hospitals, one in Lagos and one 100 km in Abeokuta were renovated to include more robust maternity services and instruction for midwives (van Tol 2007).

source of the immorality seen as inherent to African populations, rooted in notions of British cultural, and also racial, superiority.

While acknowledging the cultural imposition inherent in both colonialism and missionization, it is important to remember that missions played a significant role in the generation of the African elites who worked to overthrow colonialism (Peel 2003). Christian missions were not always aligned with the colonial project; and especially in the case of the Yorùbá, missions were shaped to a large extent by the people they sought to convert. Bishop Samuel Ajayi Crowther, the first African bishop of the Anglican Church, is exemplary in this sense.[30] He was particularly successful among the many *Saro*[31] missionaries, who paved the way for the indigenously-led churches to follow. As Christian churches willingly expanded to encompass the particularities of their diverse pastorates, central authority weakened and a series of prophet-led African Independent Churches emerged. As I show in the next section, some of these earlier movements later aligned themselves with Pentecostal churches abroad and pushed against biomedical practices, which they saw as undermining their faith in God. Christian missionaries, initially the force behind the provision of biomedical services, were thus also responsible for inciting one of biomedicine's major oppositions in Nigeria.

Healing, praying and the origins of Pentecostalism in Nigeria

Pentecostals, while diverse, are distinguished from followers of other Christian faiths by a belief in the occurrence of "the miraculous"—the direct action of God—in everyday life.[32] In

[30] See Page and Crowther, *The Slave Boy Who Became Bishop of the Niger* (1888).
[31] The *Saro* were formerly enslaved people of African descent (the single largest contingent being Yorùbá), who returned to their natal homes (from the Americas, Britain and Sierra Leone) and, influenced by experiences of conversion abroad, began to spread the Word of God.
[32] Although Pentecostals might be seen as closely resembling evangelical Protestants in many of their doctrinal beliefs, Pentecostals more passionately affirm that the practices of speaking in tongues, prophesy, divine healing and becoming "filled with the Holy Spirit" as described in the New Testament *Book of Acts* are as relevant today as they were at the original Pentecost.

the contemporary secular moment, the results of a Weberian disenchantment[33], this insistence on the *this-worldliness* of the power of God sets Pentecostalism apart (although one could argue that other Protestant denominations as practiced in Nigeria blur this distinction as well). After baptism with the Holy Spirit, Pentecostal Christians believe that they can become empowered with spiritual gifts as described in the New Testament book, *Acts of the Apostles*, including prophecy, speaking in tongues (*glossolalia*), and faith healing. Their style of worship is emotionally explicit, passionate, embodied, and often described as both trancelike and ecstatic. As an evangelical movement, Pentecostalism has gained traction throughout the global South in the past few decades (Robbins 2004), but it has an especially long and rich history in Nigeria dating back to the early 1900s.[34]

Of the religious practices and experiences that differentiate Pentecostals from other Christians, faith healing—healing by divine intervention elicited through prayer—is the most commonly reported.[35] Just as missionary success relied heavily on the persuasive power of biomedical care, the first African independent religious movements in Nigeria were centrally concerned with healing. In Nigeria, the 1918 influenza epidemic served as a backdrop for the renewal movements that would later give birth to many Pentecostal churches including the CAC**.** Although short in course in Nigeria, the epidemic is estimated to have affected fifty percent of the population and resulted in the death of hundreds of thousands of Nigerians.[36]

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[33] Weber's disenchantment thesis—that Protestantism instigated a process of disenchantment that culminated in the decline of religion—is indicative of the modern secular approach in that, as Ian Whitmarsh notes, "Weber's notion of secularization is then no death of the religious, but the dispersal of religious ethics and meaning into institutions that then remove their religious reference" (Unpublished manuscript).

[34] For an in-depth study of the history of classical Pentecostalism in Nigeria, see Peel, *Aladura: A Religious Movement Among the Yorùbá* (1968), and Fatokun, "The 'Great Move of God' in an African Community" (2009). See, also, Gaiya, "The Pentecostal Revolution in Nigeria" (2002) for a study of neo-Pentecostalism.

[35] See Luis Lugo et al. 2006.

[36] *Nigeria: Report for 1918* (1920). Although the epidemic ended just three months after its introduction by British ships coming from Sierra Leone, in Lagos 50% of Nigerians were affected with a 5% mortality rate, noted to "probably be a low estimate" (1920, 19).

The few hospitals were not only overwhelmed by the sheer magnitude of those affected, but the biomedicine practiced at the time could neither explain the cause of the epidemic nor alter the course of the disease. The British adopted quarantine measures, prohibiting public gatherings, which included the closure of churches. It was in this context, amidst a deadly epidemic, controlling colonial forces, and rigid mission churches, that the practice of Christianity among the Yorùbá was transformed (Peel 1968a). While I think it is important to describe the historical conditions within which Pentecostalism originated among the Yorùbá, I do not provide them as causal explanations. These dynamics underscore the fact that Pentecostal practices emerged across Africa in a variety of settings which could generate a multitude of possible causes. More importantly, people began to make sense of and respond to the virulent influenza virus through a vigorous form of worship marked by its asceticism and emphasis on prayer.

This movement, the *Aladura* or "praying people" movement, began as small groups of particularly enthusiastic members of Protestant churches led by charismatic prophet-healers. In her institutional history of the CAC, Crumbley (2000), foregrounds the story of Daddy Ali, a sexton (church groundskeeper) at St. Saviour's Anglican Church in Ijebu-Ode, a town in present-day Ogun state, (westward of Ondo).[37] At the height of the influenza outbreak, Daddy Ali had a dream that the entire parish was covered in darkness except for a small portion that was full of light. He interpreted his dream as a revelation. Those in the dark were church members who were using medicine to heal the sick while those few in the light were relying on their "faith alone" (Crumbley 2000, 169). Daddy Ali's dream was not taken seriously by the parish priest to whom he reported. However, after having the dream a second time, he decided

[37] While Crumbley specifically offers personal communication with Abraham Olutimehin, the fifth general superintendent of CAC, as her source, this story of the origins of CAC is widely repeated.

instead to tell some of the Yorùbá church lay elders. They were so moved by Ali's vision that they took action. While the church was closed per colonial decree and the priest had temporarily vacated his post, these lay elders began to meet in the home of Joseph Ṣadare. Around the same time, Sophie Odunlami, a school teacher who herself had suffered from a mild case of influenza, was also having dreams instructing her to use prayer and consecrated rainwater to heal the sick instead of medicine. These revelations together were the basis for the formation of the Precious Stone (Diamond) Society, a special prayer group within the structure of St. Savior's Anglican Church with the goal of healing influenza victims.

The Precious Stone Society held regular meetings, emphasizing faith healing, biblical literalism, and impassioned spontaneous prayer. The society continued to grow in size and evangelical momentum, creating tensions within St. Saviour's Anglican Church. By 1922, conflict between the society and the Anglican church over the practices of faith healing and prophecy had become irreconcilable. Members of the society were forced to resign from the church. By this time, the society had already made connections with a Holiness church in the United States—Faith Tabernacle of Philadelphia—and a formal affiliation was forged in 1923. This connection was the result of David Ogunleye Odubanjo happening upon *Sword of the Spirit*, a publication of Faith Tabernacle that promoted healing by faith alone, and showing it to Precious Stone Society leaders, who encouraged him to communicate directly with Ambrose Clark, the leader of Faith Tabernacle at the time.

Crumbley argues that this affiliation was strategic in order to add legitimacy to the church and avoid colonial interference (2008, 32). The British were becoming increasingly suspicious of African-led churches and had already put a stop to a similar movement in the

east.[38] This also might explain why the group kept the name, Faith Tabernacle of Nigeria, even after their brief affiliation with the Philadelphia church. The split was attributed to differences in style of worship (with Holiness churches being far less emotional in prayer as well as being skeptical of the glossolalia, dancing, drumming, and bells of the Nigerian church) and attitudes toward private property (which the Philadelphia church did not condone). Free of their U.S. affiliation, Faith Tabernacle of Nigeria spread to other parts of Yorùbáland including Ibadan, where they met a semi-literate self-proclaimed prophet-healer, Joseph Babalola. According to CAC's official history, Babalola had received a divine call that transformed him into a great prophet in 1928 while on the job as a mechanic for the colonial Public Works Department (Fatokun 2006). After a period of fasting and prayer, he claimed to have been commanded by God to share his healing powers. He began attracting large crowds with the miracles he performed, one of the first being the successful delivery of a woman who had been pregnant for four years. He too preached healing by faith and *omi iye* [holy water] alone. Upon being introduced to the leaders of Faith Tabernacle of Nigeria, he was welcomed into the church. Soon after, his reported resurrection of a dead child initiated a series of revivals beginning with the Great Revival of 1930, which spurred the conversion of thousands (Fatokun 2006).

Threatened by the rapid success of an unorthodox indigenous movement and emboldened by the church's unaffiliated status, both colonial and missionary officers sought to intervene. Traditional leaders were persuaded not to sell land to the church and mission schools banned the children of Faith Tabernacle of Nigeria members. Finally, Babalola was imprisoned for 6 months under the charge of "witch-hunting." At least partially to escape

[38] Garrick Sokari Braide was an Ijaw prophet-healer with a massive following in the 1910s in the CMC Niger-Delta Pastorate when he was jailed by colonial officers under the charge of inciting insurrection. Soon after release from his almost two years of imprisonment with hard labor, he passed away. After his death, the movement lost much of its initial momentum, although his followers constituted themselves into Christ Army Church.

colonial surveillance, Crumbley argues that the church sought an affiliation with the Apostolic Church of Great Britain in 1932 (2008, 34–35). The leaders of Faith Tabernacle of Nigeria were also introduced to this church through its publication, *Riches of Grace*, which had made its way to Lagos. While this affiliation made more sense than the last given the shared practices of prophecy, biblical literalism, glossolalia, and spiritual warfare against evil forces, it was short-lived. The British Apostolic missionaries had helped to facilitate negotiations with colonial officers and traditional officers, allowing them to buy land, build churches, and open schools, but tensions once again arose over the doctrine of faith healing. The Nigerians were disillusioned by the British use of quinine to protect against malaria, which they considered to be a sign of weak faith, and also felt their power of self-determination slipping away. Under Babalola's influence, the independent Christ Apostolic Church (CAC) was officially established in 1941 (Peel 1968a).

As leader of CAC, one of Babalola's early acts was to establish a maternity school in order to address the large proportion of reproductive concerns that brought people to the church. CAC was organized according to a sexual division of labor with those roles intended for women to be largely associated with reproductive functions[39] related to an emphasis in the church on 1 Timothy 2:11-15:

> Let the women learn in silence with all subjection… Notwithstanding she shall be saved in childbearing if they continue in faith and charity and holiness and sobriety.

Thus, while women were prohibited from being ordained as pastors, they played active roles in leading the church programs that supported the reproductive lives of women including special prayer meetings and maternities, now commonly known as *mission homes*. This was such an

[39] Crumbley writes about notable exceptions within the CAC and other Aladura churches in *Spirit Structure and Flesh* (2008), most specifically in the chapter, "Gender and Power Within and Without Church Structures."

important aspect of the church that the original CAC constitution read as follows:

> Expectant mothers of our church ought not go to any hospital/maternity home either for check-up or childbirth since the Bible has promised us good care and safe delivery (Isaiah 40:11; 66:9; 1 Timothy 2:1). Anyone found guilty of the above shall be suspended from sharing of the Holy Communion for a period of months. If…enforced on women under Government Service, they shall not be penalized by the Church; but since they can be tempted to fall off the path of faith laid down by the Holy Bible they should obey the government regulation but actually depend on the promise of God of pregnant women (CAC, quoted in Crumbley 2008, 38).

This founding tenet of the CAC cemented a refusal of biomedicine, which had become a defining departure from the practices of European missions. Although the bylaws have been updated since then to allow for the use of biomedicine, they have left a legacy of aversion to biomedicine and the perception that those who use it are of weak faith. It is also significant that childbirth is singled out as it marks an important continuity between Aladura and Yorùbá traditions.[40] Reproductive desire—for fertility, safe delivery, healthy babies, maternal survival—is a central feature of Yorùbá culture (Dopamu 1982). Yorùbá converts had an interest in making sure that their new religious practices would meet these desires, while church leaders were charged with providing for the reproductive well-being of their members.

Reproductive Desire, Revival, and Redemption Camp

Reproductive desire figures even more centrally in the origin story of the RCCG. Similar to Babalola, Josiah Akindayomi moved from the Anglican church toward the Aladura movement before establishing an independent church. Akindayomi was born into a family of worshippers

[40] Ray (1993), Ogungbile (1997), Omobola (2014), and Dada (2014) write the persistence of elements of Yorùbá culture into Aladura religious practices.

of *Ogun* (the Yorùbá deity of iron and war)[41], but was converted into the CMS Anglican church in his hometown in Ondo state during his pursuit of formal education in his late teenage years. This educational project was abandoned when he joined Cherubim and Seraphim (C&S) a few years later in 1931, and he never became fully literate (Ukah 2003).

Akindayomi later moved to Ile-Ife and then Lagos, where he worked as an (unpaid) itinerant prophet for C&S. As a prophet, he gained a considerable following and people visited him for consultation before long journeys or important domestic decisions. However, he achieved particular recognition through his ministry to infertile women, providing spiritual care (both in terms of guidance and healing) to pregnant women and their infants. His church was filled with women from neighboring towns seeking fertility, successful deliveries, and the welfare of newborns. Gradually, the church became a place where women delivered under the spiritual protection that Akindayomi was known for.

Akindayomi was compelled to start a prayer fellowship group, which was called Egbe Ogo Oluwa (Society for the Glory of God). Originally a group within the C&S church, Egbe Ogo Oluwa rapidly grew in size and began to see things differently than its parent church. In 1952, the group officially parted from C&S, and RCCG was born. Responding to the desire many women had for births within the presence of God, Akindayomi founded an official maternity practice in 1962 in Lagos headed by his wife, who had trained to become a midwife. While the relationship between Nigerian Christians and faith healing began, in part, in the setting of the influenza epidemic, the massive growth of Pentecostal faiths in subsequent years was strengthened by attention paid to the reproductive concerns of women. Mission homes emerged as a response to the great reproductive demands of Pentecostal congregations.

[41] Aonezeh Ukah also notes that he became "a renowned and expert herbal healer or traditional medicine man…a *Babalawo*," and "achieved a somewhat quasi-official status as a ritual functionary of Ogun (2003, 44).

Reproductive desires not only contributed to the conversion of thousands of young adults but, along with other desires for good health, they changed the nature of worship. Faith healing, around reproduction in particular, gained significance and new leadership roles were created for women within the church. This facet of the church's social life, concerned with fertility, remains an important aspect of the RCCG's identity, but following the death of Akindayomi, RCCG transformed significantly and so too did its relationship with biomedicine.

Before his death in 1980, Akindayomi chose Pastor Enoch Adeboye, University of Lagos lecturer in mathematics, as his successor.[42] At this time RCCG had grown to 39 branches in southwest Nigeria. When Adeboye took over, he lead the church into a new period of aggressive expansion campaign, taking RCCG overseas and within twenty years, he had established over three thousand branches, one hundred of which were outside of Nigeria. Adeboye's reconfigured RCCG was also marked by his sermons in English (unlike Akindayomi who preached in Yorùbá), a doctrinal emphasis on health and wealth, a substantial increase in university-educated middle-class membership, and the creation of the Redemption Camp, a sacred site where God is thought to be present.

Every year in early August hundreds of thousands attend the RCCG Annual Convention at Redemption Camp on the border of Lagos and Ogun states. A sizeable portion of these attendees are pregnant women who go with the hope of delivering their babies during this week-long intensive prayer meeting. The 2014 and 2015 Conventions were like nothing I had ever seen before. I was struck by the magnitude of the operation—of everything at Camp. I mean this in the sense of the size of Redemption, a small city, and the density of people, but also, and perhaps more telling, the magnitude of emotion.

[42] The succession was enshrouded in secrecy, recorded on audio tape, and only announced publicly after his death (Ukah 2003).

Campground is a bit of a misnomer, as Redemption Camp really is more of a city, complete with RCCG school and clinics, privately owned supermarkets, restaurants, and hotels. These are all connected by paved roads upon which an informal bus system operates as well as a taxi system. At the center of it all is the "arena," a 1x2 kilometer pavilion with a stage at one end, where services are held. I was told that they were in the midst of building a new 3x3 kilometer arena because the current one is considered to be not big enough to house all the Convention attendees. Residents live and work in Redemption Camp throughout the year. On some occasions, it is teeming with people. The most notable of these events is the Annual Convention.

At the convention, all of the evening sermons are held in the arena, which also serves as a home to thousands of pilgrims who come but are unable to find more suitable accommodations. When I was looking for a place to stay two months in advance of the 2013 Convention, I was told everything had been booked by January of that year. The people that make the arena their home for the week sleep under makeshift tents constructed out of wooden benches and mosquito nets. They have coolers filled with jollof rice, stews, gari, and malt to last them the week. A few bring camping tents. Others cover the hard cement floor with fabrics or weaved mats to sleep on under the open air. Still others rest lying along the length of wooden benches or sitting up in the plastic chairs closer to the front stage. My friend and unofficial guide, Deji, told me, and I heard it repeated multiple times, that Camp was not for really sleeping. The feeling is that in order to take full advantage of Camp, every waking moment should be spent in the service of the Lord and that waking moments should be increased to take up most of the day.

The General Overseer, Pastor Adeboye, or "Our Daddy" (as he is respectfully called) gives the sermons for the week. He is an older man with youthful, kind eyes. Unlike his excitable, junior colleagues, he is slow and steady, clear, and hardly repeats himself. He does not yell; instead, he allows the microphone to do its job. During his sermons, he speaks with stern conviction but without the shouting and gesturing that one comes to expect from Pentecostal pastors. He wears nicely tailored suits that are neither too flashy nor too drab. I get the feeling his appearance is very deliberate and expertly crafted. On the way out of camp, as we drove past three enormous houses surrounded by expansive manicured lawns and gated by tall barb-wired walls, Deji told me that they belonged to "Our Daddy" and two of his sons. The RCCG church, having adopted the Charismatic fervor of the neo-Pentecostal movement that began in the 1970s and 1980s in Nigeria, is now far removed from its Aladura Pentecostal origins. Among the many innovation in religious practice, a reliance solely on faith healing has declined. At the same time, RCCG members and birth attendants still empathize the importance faith in their pursuit of healthy deliveries.

Birth at Camp

Every night of the convention, Pastor Adeboye announces in front of the several hundred thousand attendees the number of deliveries that occurred in the Camp to astounding applause. His voice reverberates through the sound system at such high amplitude that it is beyond my ability to discriminate between words at times. On the second night of the convention, he reported that as of 7:45 pm that day, fifty-four healthy babies had been born including two sets of girl twins. Tonight, he continued, we will be talking from the perspective of the flesh. We must not be lazy tonight. The issue we want to settle tonight is healing. (Crowd roars in excitement). At the end of tonight we will be able to say, "All who were present were healed." This focus on

health, especially childbirth is a recurring theme at the campground, noted and celebrated every night.

I had spent the day in the maternity clinic where most of the fifty-four deliveries had occurred. There is also a larger hospital with operating rooms for cesarean sections in the Camp, but most women deliver in the maternity clinic. Dr. Adeboye is one of the senior obstetrician/gynecologists at the Camp. He has had formal biomedical training and works in a supervisory role with the birth attendants, who do not have government-certified nursing degrees but complete two years of practical training at the RCCG maternity school. One attendant put it this way, "You people do theory, we do practical." Dr. Adeboye sees women who have reproductive health complaints in his clinic and is only called to the labor rooms, which are one flight of stairs above his office, when a complication arises. He also drives to the hospital to perform C-sections during his appointed shifts. The Convention is a busy time for him.

Upstairs in the labor area, several birth attendants were gathered near one of the labor rooms. There was a frenzy of activity going into and out of the room. I peeked in and saw glimpses of the woman who they were fussing over but nothing more. It looked as if something had gone wrong. Not wanting to be in the way of what seemed like an emergency, I backed away from the square cutout window in the door of the labor room and found a seat. When Dr. Adeboye arrived, he yelled over to me, asking why I was sitting down and had not gone inside the labor room as he marched right in. Not too long after, he shouted, "This baby is macerated!" He said again aloud to no one in particular, that the baby was macerated "Didn't you see his skin peeling? That baby has been dead at least three days." He meant to imply that there would have been nothing they could have done to save the baby since the woman was "postdates" or

presented much after her due date. I peered through the window just in time to see an attendant lower the small wrinkled body into a black bag.

With this conclusive resolution, Dr. Adeboye asked me to follow him into the next labor room, but before he could start the next exam, he was called back to check on the woman with the stillborn. She was bleeding. Dr. Adeboye told me that if I learned anything it should be that when called to examine someone who is bleeding, the first thing I should do even before checking the source of the bleeding is make sure I have IV access. If I checked the source of bleeding first and the woman bled out, I would not be able to find access later because her veins would be flat. So, he began the procedure for setting up IV fluids and sent me to get misoprostol and oxytocin, two medications used to stop the bleedings. I found the misoprostol but there was no oxytocin to be found. After the IV fluids were set, Dr. Adeboye reached a double-gloved hand into the women's vaginal canal to look for the source of bleeding. He carefully removed two blood-soaked pads from inside her and called for a cervical clamp so that he could examine the cervix. A flurry of attendants went to look for both oxytocin and the instrument. One attendant produced a small ampule of oxytocin, which Dr. Adeboye used to fill a syringe and then pushed directly into her IV line, but the cervical clamp was never found. Dr. Adeboye seemed satisfied with his exam though and put fresh pads into the woman. He concluded by placing three misoprostol tabs in her rectum and informed me that she would need antibiotics to prevent a further complication of the baby having died inside her days ago.

Next, a second patient was brought in for examination. When Dr. Adeboye asked her to remove her shirt and skirt for the exam, he noticed a scar, an indication of a previous cesarean section. He asked the attendants if they knew. They said she never told them and the woman was subsequently reprimanded for not having told anyone. This was going to be a case we would

have to keep an eye on, Dr. Adeboye remarked. He asked the woman why she had had a caesarean section for her last child and she responded, "Polyhydramnios and IUGR." Dr. Adeboye chuckled at her knowledge of the medical term for too much amniotic fluid and the acronym for intrauterine growth restriction, "What level of education did you read?" When she responded that she was a teacher, he laughed even more.

A third patient was almost ready to deliver. When it was time to push, I followed two attendants into the delivery room. From time to time, an attendant would start singing spontaneously and everyone including the pregnant woman would join in. Everyone knew the words to these praise songs. The attendants encouraged the woman to push with every contraction, but the head was far from crowning. She became exhausted and started skipping contractions, "Okay just let me rest and I will push, I promise, for the next one." The attendants continued to encourage her. At one point, the pregnant woman asked for an "induction." I asked her how she knew about inductions and she told me that her first baby had been induced. Her request was ignored and she continued to try to push during contractions. She began to pray: "God, give me the power to push this baby out." and "Baby, I command you to come out and leave this place for your juniors." The birth attendants joined her, "You will deliver."

After several minutes had passed, and no progress had been made because it was thought that she was running out of energy, the attendants boiled water for her and added "glucose" to it. I've seen the little blue tins with GLUCOSE written on the side in almost every household. The pregnant woman was fed spoonfuls of this hot water-glucose mixture. I worried aloud that she might aspirate some food into her lungs and wind up with an infection. The attendants said that she would not because they would pray, "You know we are praying here." We stepped outside, giving the laboring woman a chance to rest, and some people came in to immunize the baby that

was expected to come out of the woman who had actually had a stillborn. A hushed silence fell over the room and lingered for some time before one attendant explained to them that they did not need their services, never outright saying that the baby had died. I noticed a woman filling in a record book for a baby that had been born earlier and I asked her if I could see it. I noticed the stillborn from earlier that morning had not been recorded. I asked the one trainee why and she said that it was because the baby had died. This seemed peculiar to me since the records had a column for status of baby and mother. And each was filled in the word, "ALIVE" for every patient. I sat in the larger labor ward with the other attendants and trainees as they chatted about the previous miraculous deliveries that they had witnessed.

The woman continued to push, but at one point an attendant came out to say that the anterior lip of the cervix was still showing, while posterior part was fully dilated. This might be the problem. The woman said she felt like throwing up and I wondered out loud if she should have been fed. The attendants laughed and said it will be good for her to throw up, it will help the baby down. I worried again about aspiration. Finally, about an hour after she started pushing, the attendants asked me to get Dr. Adeboye. He was not downstairs in his makeshift office or the consultation room. He was nowhere to be found so I called him on my cell phone several times before reaching him. When I finally got through he said he would try to send someone to come because he was far from the maternity center. The doctors arrived just as the baby was coming out. The healthy baby boy was placed immediately on his mother's chest.

On my way home that evening, I checked out the building next to the maternity clinic. It was rich with the smell of pregnancy (hard to describe but definitely distinct, like iron and alcohol), which I could perceive before I even entered. Once inside, I saw women on beds, chairs, against the wall, on mats, fully laid out, crouched in balls, sitting upright. Every position

imaginable in a diverse assortment of dingy colored ankara clothes. All waiting, praying for labor so that they could be transferred to the clinic next door and succeed in having their babies inside camp during the convention, the holiest time, the holiest birth.

Childbirth at Camp is evidently a faith-enriched process but Redemption Camp also provides biomedical care. In this way, it resembles the government hospitals that one might find in Ondo more than mission homes. Away from the excesses of the Convention, at RCCG and CAC churches across the country, women seek holy births in more intimate settings.

Mission homes today

As Pentecostal churches spread in a second wave beginning in the 1960s and '70s, mission homes have flourished. In one of the only studies to have focused on mission homes in Nigeria, it was estimated that at least fifty percent of births in a Yorùbá town in southwestern Nigeria took place in mission homes (Adetunji 1992). Mission homes are spaces where pregnant women go for perinatal care (even though many of them are not members of the particular church). Women meet for weekly prayer meetings over the course of their pregnancy until they finally go into labor and deliver. They are run by "sisters" with varied levels of training. Some spend two years in central Pentecostal training camps while others learn from members in their local church. Sisters are on-call in the mission home to attend to deliveries that need to be taken at all hours. They are paid by the church and often live in the mission home for weeklong shifts. Although there may be some overlap, the women who work at mission homes differ from what is commonly assumed to be a traditional birth attendants, a trade often passed down in families and not necessarily associated with Pentecostal churches. For these reasons, I refer to them as *faith attendants*, but it is important to note that these lines are blurry as well.

Both the CAC and RCCG sponsor training for faith attendants. There are two CAC midwifery training centers in small towns in Osun and Ekiti states and one RCCG midwifery school at the Redemption Camp maternity. Both are two-year programs that follow an apprenticeship model, with increasing responsibility in the second year. Prayer is a big component of each training center, but at the CAC's mission homes, women must pray and fast around the clock for the first and last seven days of their training. This prepares them to answer the call to maternity work and sanctifies the training they have received before they go out to run their own mission homes.

Mission homes provide an atmosphere of comfort and support during delivery, pre- and postnatal care, and education. They have become alternatives to biomedical hospitals, using prayer and faith rather than biomedical care as a way of assisting childbirth. Pregnant women generally attend weekly prayer meetings (usually on Tuesdays or Wednesdays) where at the very least their weight is taken and their abdomen is palpated. At most, their blood pressure is also taken, the fetal heart rate is measured, and their urine is tested for early signs of preeclampsia, a potentially life-threatening disorder of pregnancy and a common cause of maternal mortality.[43] This initial check-in is followed by songs of praise and worship, a short sermon by one of the faith attendants or the pastor, and finally a "health talk." During the health talk women are given advice about how to care for their pregnancies. Topics range from diet and exercise to danger signs in labor. The meeting closes with an offering and a prayer. However, much like their doctrines and church membership protocols, prenatal care in CAC and RCCG mission homes differ dramatically.

[43] Preeclampsia is most often characterized by new onset high blood pressure after 20 weeks of pregnancy and the presence of protein in the urine. If left unmanaged it may progress to eclampsia, which is marked by the presence of seizure.

RCCG mission homes often embrace biomedicine alongside faith healing. The Redemption Camp maternity and hospital employ physicians that perform Caesarian sections when labor is prolonged or otherwise obstructed. While smaller mission homes in rural areas do not have operating rooms, biomedical equipment, or the ability to place intravenous lines for blood or rehydration, they often refer their patients to local biomedical clinics. Most mission homes in urban centers do not offer what one might expect from a biomedical hospital, but members of the congregation who are biomedically-trained volunteer to be contacted on an on-call basis in emergencies.

CAC mission homes tend to be far more averse to biomedicine. The spaces are often sparsely adorned, sometimes with little more than a bible and a mat. While most mission homes, including those associated with CAC, now allow their members to seek care outside of the church, the legacy of the church's founding principles are evident in the strong aversion to biomedical interventions, drugs, and Caesarian sections among many congregations. CAC prayer meeting often begin with a cautionary tale about the dangers of going to a hospital, understood as a sign that the person did not put their complete faith in God. As a result, in Nigerian communities, mission homes are often positioned against state-sponsored biomedical centers. They are seen as major contributors to maternal mortality by Ondo state officials and doctors. Once venerated as symbols of African independence, mission homes are now considered threats to the state by the ministries of health, doctors, and community health workers due to their reliance on faith above all else.

During my fieldwork at MCH, any woman who arrived at the hospital in a dire state was assumed to be coming from a mission home. When I asked an elderly nurse in the MCH post-natal ward about mission homes, she replied simply, "It's bad, very bad." In hospitals,

mission homes are often associated with poor hygiene, inadequate care, high rates of infection, death, and ignorance. The nurse later told me, "If I had it my way, I would say they should be eradicated or they should be invited for training so they can know their boundaries. It's possible to train them, but training has a limit." And, she recounted a story of a woman who had lost her life because of her decision to deliver in a mission home, "We have seen someone who has come in dead, stone dead from the mission home." She continued:

> Will prayer solve the problem of obstructed labor? Will prayer fix a transverse lie? Oblique presentation? God will only answer your prayer if you are right thinking, if you take the right steps.

This disapproving, at times hostile, attitude toward mission homes and the use of religion to solve problems in the material world were echoed among many of the hospital staff and administration.

This logic is problematic in many ways. Aside from the unsubstantiated assumption about the quality of care given in mission homes, government officials also imagine the hospital and church as separate and discrete. In fact, as I show in Chapter Four patients seamlessly transition between one and the other, often piecing together their own personal therapeutic plan. It becomes hard to tease out where responsibility lies for the death of any woman whose mortality is the end point of a series of movements through spaces that are both religious and biomedical. What happens when someone dies in hospital after initiating labor in a mission home? Who is to blame when a woman attends a hospital antenatal clinic for the duration of her pregnancy, but insists on giving birth in a mission home? Or, as was the case in the most tragic example that I witnessed, when a woman bleeds to death in a taxi outside the hospital because the hospital refuses to take her, fearing she would add to their death toll?

Despite the abundance of confounding variables, religious fanaticism is continually blamed for continued high rates of maternal mortality in Nigeria. This contributes to the widespread assumption that religion in the Nigerian public sphere is backwards, ignoring the range of Pentecostal approaches to maternal care, including much of what transpires in hospitals. And, it is crucial to consider the pivotal role of women at the center of this conflict between religion and state. Women's bodies and reproductive processes form a contested site through which the state hopes to be read as modern in much the same way that women were targeted during Nigeria's colonial period as discussed above. Once again, in the present moment, Nigerian women are seen as a platform upon which to build a case for progress. The state sees those who choose to deliver in mission homes as backwards rather than faithful, ignorant rather than making a conscious well-informed decision about their care.

Whereas Protestant Christianity was once seen as a key source of modernity bringing with it biomedicine, the contemporary healing techniques of Pentecostal birthing practices are seen as backwards. The stance disregards the existence of a long history of ties between healing and Christianity, as I have demonstrated. The line between "progressive" religious practice and "backwards" fanaticism in relation to medicine continues to be drawn and redrawn over time, but has never entirely excluded Christian sentiments and protocols. Indeed, Christian practices and ideologies have been incorporated into biomedical clinical practice. Exploring reproductive desires (and the importance of motherhood) as a feature of Yorùbá culture helps us to better understand the development and rapid expansion of Pentecostalism in Nigeria. It is also an important context for present debates concerning the role of religion in maternal mortality. In following the lineage from the Anglican church to the Aladura movements to the CAC and RCCG churches, what becomes visible is the powerful

codependence of biomedicine and Christianity throughout.

A range of political economic dynamics have contributed to the significance of mission homes, including a series of military coups, the introduction of structural adjustment programs, and the subsequent deterioration of the national health care system. But there are two other phenomena that need to be accounted for in explaining why mission homes are not simply a response to a failed state. Firstly, mission homes attend to Nigerians across class and status boundaries, numbering among their patients are doctor's spouses, university students, rural farmers, and urban market women, in addition to people perceived as poor and illiterate. Taiwo, above, was in the middle of a university exam when she fell into labor and immediately made her way to the CAC mission home. Secondly, in Ondo State, the government has invested in impressively robust biomedical maternal health care infrastructure comprised of state-of-the-art hospitals, ambulances, and instruments, all of which are free to the public. Despite these factors, women continue to utilize mission homes in large numbers as their primary or exclusive form of pregnancy care. Taiwo had to pass at least three hospitals on her way from the university to the mission home.

Coda: A church birth

In contrast with my clenched fists and Dr. Yemi's anxious pacing, Sister Ṣola was entirely calm. She gently tickled Taiwo's belly to stimulate contractions. "*Ti o ba ti mu e, push*," Sister Ṣola continued to tell Taiwo. And Taiwo, perhaps strengthened by her words, indeed continued to push. We could just barely see the baby's head, but it seemed suspended. Mrs. Oke called for Sister Ṣola to bring her scissors. Dr. Yemi nodded in agreement. The consensus was that Taiwo needed an episiotomy in order to create enough space for the baby to come out. Taiwo looked terrified. "What do you think?" They looked at me. I thought maybe we could wait for just one

more push. The baby is almost out, right? I do not know why I was so attached to the idea of her not having an episiotomy, but I was. After another unsuccessful attempt at pushing, Mrs. Oke picked up the scissors and made the necessary cuts.

I looked up at the clock and it was exactly midnight when the baby came out with his cone shaped head, a sign of a prolonged final stage of delivery. “Praise the lord,” shouted Mrs. Oke and we all responded, “Hallelujah.” Mrs. Oke and Sister Ṣola started to sing a song in Yorùbá, so low it sounded like a pleasant hum at first. Taiwo, weak, joined in. Dr. Yemi cut the cord. In quick succession, the placenta was delivered and Mrs. Oke stitched the cuts that had been made to allow for the baby to exit. Meanwhile Sister Ṣola dried and cleaned the baby. All of this was done while singing.

Mrs. Oke cleared the baby’s mouth and nostrils with a suction device. Dr. Yemi looked at me with a sort of I-told-you-so look. “This is so backwards,” he whispered. The baby was thoroughly cleaned over the course of half an hour. First, he was patted with a dry towel. Then he was rubbed all over with oil. Next, he was given a soap and water bath. Finally, he was wrapped in a soft blanket and given to his father. The father beamed, “It’s a man!” He thanked Dr. Yemi and I profusely even though we did not feel like we had not done much. Sister Ṣola made milky tea. I watched as she brought a metal cup up to Taiwo’s lips, giving her a few sips every few minutes.

Dr. Yemi and I left at close to 1 am. In the car, there was a palpable sense that we had narrowly escaped terrifying alternate ending to the birth. I breathed an audible sigh of relief. Dr. Yemi asked me if I was happy now that I had seen a birth in the mission home. I was not sure how I felt. “Just don’t ask me to bring you here again,” he laughed.

Chapter Three
Questioning "Safe Motherhood": Race, Representation, and Reproduction

"Start the story with the failure of the African state and not the colonial creation of the African state and you have an entirely different story."
– Chimamanda Adichie, "The danger of the single story"

In 1987, the World Bank, World Health Organization (WHO), and the United Nations Fund for Population Activities (UNFPA) joined forces to convene the first ever international conference focused solely on the problem of maternal mortality and morbidity. The International Safe Motherhood Conference in Nairobi would be only the first of a self-propagating series of national, regional, and international calls to action, conferences, task forces, congresses, programs, initiatives, and countdowns centered on the health of pregnant and birthing women and involving governments, donors, non-governmental organizations (NGOs), and technical assistance organizations. The seeds for such an occasion had been planted years earlier when the then director-general of the WHO, Halfden Mahler, revealed at the 32nd World Health Assembly that an estimated 500,000 people died each year due to obstetric complications and that 99% of these deaths occurred in Africa, Asia, and South America (Mahler 1979). Prompted by such alarming statistics and the disproportionate lack of action, six years later, Allan Rosenfield and Deborah Maine published a seminal paper in order to raise awareness for the "neglected tragedy" (Rosenfield and Maine 1985). In November of that same year with the support of UNFPA, WHO convened the Interregional Meeting on the Prevention of Maternal Mortality, where even more data confirming previous estimates was presented. By the of the end this meeting, the attendees—41 health professional, researchers, and policy makers from 26 countries—were in agreement that "a major initiative to prevent maternal death should be mounted—and was in fact overdue" (WHO 1986). Thus, *Safe Motherhood* was born.

While interest in the health of mothers and children predates the 1987 conference (See AbouZahr 2003), two innovations, one technical and the other ideological, mark Safe Motherhood as a break from past women's health frameworks. First, new statistical techniques made it possible to produce the first estimates of the extent of the problem. Using data available from civil vital registries, hospital audits, and household surveys in a sample of low-income countries (WHO 1985), the WHO was able to make numerically concrete a problem that had otherwise been speculative. The new numbers exposed disparities between low and high-income countries and also gave the movement a goal toward which interventions could be aimed; the maternal mortality ratio had to be decreased. Second, Safe Motherhood is marked by its paradoxical emergence in the wake of economic recession, structural adjustment, and the eventual abandonment of the 1978 Alma Ata Declaration. The original commitment made by the WHO at the International Conference on Primary Health Care had been to support "Health for All" by strengthening primary health care and addressing underlying social, economic, and political determinants of health was never realized. As a result, while most in public health would agree that successful deliveries require comprehensive primary health care systems that address these determinants of health, Safe Motherhood is more selective in its aims.

In this chapter I interrogate the configuration of discursive practices and health initiatives around maternal mortality since its conception as an international problem in 1980s under the rhetoric of Safe Motherhood in order to explore how African women are deployed in development schemes. I pay attention to the speeches and textual representations promoted by what we might think of as the maternal health development regime in relation to practices, techniques, strategies, and material operations of power in Ondo. As mothers, women are treated as valuable socially, economically, and morally; consequently, their motherhood is elevated

above any other aspect of their condition. Population control, and therefore African women's bodies, has been a central concern for development programming in Africa since colonialism and remains a chief target of state intervention and global health policy in the postcolonial present under the guise of Safe Motherhood, family planning and reproductive rights. The mid-1980s, however, marked a significant moment for maternal health. Amidst a new awareness of disparities in maternal mortality rates between high and low-income countries, detailed anecdotes of women dying during childbirth emerged as a tool to garner political and economic support for global health interventions aimed at women, or rather mothers.

Central to the rhetoric of Safe Motherhood is the *maternal death narrative*. While successfully raising public concern and financial support, it is important to ask what else the genre of maternal death narrative does. What possibilities are foreclosed? How might discursive practices around childbirth and motherhood structure the care offered to African women? And what role do anthropologists as ethnographers play in this form of knowledge production, authorization, and promotion? In this chapter I argue that we have as much to gain from maternal *survival* narratives as we do from these often-told maternal death narratives. Borrowing from writer Chimamanda Adichie's notion of the single story, I argue that the danger of the single story has implications for global health too. I introduce African women's literature as a way of complicating representations of African women and thus rethinking possibilities for maternal care. In concluding, I employ a critical racial analytic lens, engaging recent debates around afropessimism to explore the practices and ideologies inherent to global health in postcolonial settings across the global south. What happens when African death is the driving force of inquiry?

Mothers in Development

The Safe Motherhood Conference was quickly organized to respond to heightened concerns and took place over the course of four days in February of 1987. In addition to the leadership of the convening organizations, in attendance were several African, Asian, and South American ministers of health including the minister of health of Nigeria at the time, Dr. Olikoye Ransome-Kuti, the son of prominent women's rights activist Funmilayo Ransome-Kuti and brother to legendary musician and activist Fela Kuti. There is much in the WHO archives that provides a picture of constructions of the problem of maternal mortality engendered by the conference, but I will focus on three quotes that summarize the sentiments of the day. First, the conference opened with remarks by Barber B. Conable, the then president of the World Bank. Setting the tone for the four days of sessions that would follow, Conable described the problem in economic terms:

> Working for safe motherhood, we will be working for steady development on all fronts. Maternal health care…is an investment in development. It is an affordable and productive investment (Conable 1987, 155).

Next, Mahler began his address by quoting, of all texts, the Book of Genesis:

> In the Book of Genesis we may read these words: "Unto the woman He said, I will greatly multiply thy sorrow and thy conception; in sorrow shall thou bring forth children." But in the present time, neither the conception nor the sorrow is evenly distributed about the world. Surely the most striking fact about maternal health in the world today is the extraordinary difference in maternal death rates between industrialized and developing countries (Mahler 1987).

And, finally, in the "Call to Action," adopted by consensus at the conference, it was noted:

> We need to remember that the industrialized countries faced this challenge in the past. For some the change has taken place in our lifetime, through dedication and the reallocation of priorities (Starrs 1987).

These three quotes taken together are both representative of the larger Safe Motherhood agenda and illuminating of constructions of Africa, African women, and maternal mortality that continue to pervade the discourses of Safe Motherhood. They marry the economic, the religious, and progress in ways that are eerily reminiscent of an imperialism that never quite expired. As Michel-Rolph Trouillot notes, "modernity is necessarily plural…it requires an alterity, a referent outside itself—a pre- or nonmodern in relation to which the modern takes its full meaning. It is historically plural" (Trouillot 2002, 222). This plurality is produced through both the management and imaginary projection of populations external to what he calls the North Atlantic. The "Call to Action" places countries like Nigeria in a Hegelian racialized teleology[44], in which the "Geist" necessary to propel them forward into the "theatre of History" has yet to be incited. The global story of maternal health is often told in this way.[45] The countries of western Europe and the United States too contended with high rates of maternal mortality until the advent of certain technologies, antibiotics, and standards of obstetric care. They serve as the models from which African countries should take lessons. Often, political will and gender equality are highlighted as making the crucial difference. These stories, of course, leave out the centuries of racialized violence and exploitation that made such uneven industrialization possible.

What is significant about Mahler's bible reference is the simultaneous gesture to the WHO's Christian underpinnings and also, relatedly and not in contradiction, its secular mission. Christianity played an important role in the civilizing mission of Frederick Lugard's "dual

[44] In "Geographical Basis of History" in *Lectures on the Philosophy of History* (1837).
[45] See, for example Van Lerbergheand and De Brouwere (2001).

mandate," and religious justifications for intervention lie at the core of WHO's mission. The Christian Medical Commission (CMC), "born out of a belief that there is something peculiarly Christian about the business of health and healing" (Smith 1998) as the medical outreach arm of the World Council of Churches (WCC), was the first major NGO to partner with WHO.[46] CMC stimulated discussion at WHO about the then radical approach of community-oriented primary health care well before it was presented at Alma Ata (Smith 1998, Litsios 2004). Alma Ata's Health for All was, however, never fully realized and CMC and WHO parted ways ideologically. Whereas CMC continued to be motivated by an idea of "wholeness," the WHO, increasingly beholden to economic forces, supported a *selective* primary health care model.

Finally, Conable's comment brings capitalist motives into sharp relief, and is also indicative of a trend, which started modestly in 1979 with the World Bank's creation of the Health, Nutrition, and Population sector and has only accelerated in the last two decades. It is what Devi Sridhar has called "the economic gaze," the latest in a line of organizing principles for public health policy, from Michel Foucault's clinical gaze (medicine) to David Armstrong's community gaze (epidemiology), to the present moment in global health, which she argues is dominated by economic concerns (Sridhar 2011). The World Bank's increasing involvement as an economic institution has impacted health policies and projects substantially. Sridhar notes how terms like "human capital" and "cost effectiveness" have become mainstays in global health, ordering how interventions are designed, assessed and funded, while DALYs are commonly used to estimate the burden of disease. These are innovations of the World Bank,

[46] The WCC administrative office was and still is a short five minute walk from the WHO headquarters in Geneva, allowing for easy communication between the two organizations. Soon after Mahler was elected to director-general, he began to follow closely the activities of the CMC, which were driven by a rights-based, social justice framework. Impressed with their community-centered, "whole person" approach to health promotion in rural areas, Mahler strengthened the WHO's already informal relationship with CMC through a series of conversations and meetings with the CMC leadership. WHO's principles of primary care emerged from these conversations and CMC had a significant presence at Alma Ata (Smith 1998, Litsios 2004).

which is now the largest funder of global health within the UN system and second overall only to the Global Fund[47] (Sridhar et al. 2017).

When during the summer of 2013 a woman died at Mother and Child Hospital (MCH) in Akure, the chief medical director concluded a long discussion of her last hours in the hospital the next day during "morning report" on this somber note: "This is a serious issue. A woman has just died. A mother has just died. A wife has just died. A daughter has just died. We don't even know the economic contribution she was making to the family." The singular concern with productivity and economic results in bodies that only have value in so much as they enhance the global economy. Target groups are created with this justification because it is their health that will have the greatest ramifications for the productivity of countries. Mothers, or rather pregnant women, became central development targets through Safe Motherhood, making claims to health care contingent on specific notions of economic productivity.

In Ondo, *Abiye* offered free health care to all pregnant women and children under age five. Two tertiary hospitals, (MCH-Akure and MCH-Ondo town) were built and many other primary health centers were renovated in ways that allowed them to efficiently cater to only these specific populations. On another day in the same summer, I was introduced to Rachel. Rachel had just had a Cesarean section and was lying in the annex to the operating room, which served as a makeshift ICU. An ankara cloth did little to conceal a large protrusion mass just above her belly button. Outside her room one of the doctors explained to me excitedly, "Fibroids!" He showed me the pictures on his cell phone of her uterus, contorted with large fleshy spheres. "Did you take them out?" I asked. He laughed confidently, "Take what out? We sewed her back up!" Because MCH specializes in pregnancy and infant care only, it did not offer

[47] However, Sridhar et al. (2017) note that Global Fund is financed by trust funds held at the World Bank.

comprehensive obstetrics and gynecology. It should, of course, be noted that the sheer number of deliveries per day overwhelmed the small cadre of doctors, and the surgeons felt justified in not performing beyond the principal exigency of taking healthy babies out and making sure mothers lived.

In emphasizing the reproductive and productive capacities of women, Safe Motherhood constructs mothers as not only the main targets of global health programs, but as markers of development. That the previous millennium development goals and current sustainable development goals of the United Nations feature prominently the improvement of maternal health in this specific way is another suggestion of this. Clare Wendland (2016) describes why reproductive health indicators like maternal mortality matter to health policy makers beyond the deaths they represent. She notes that the significant gap in maternal mortality ratios between rich and poor regions in a time when most causes of maternal death are preventable is a sign of gender and class inequity; that disruptions in reproduction signify political illegitimacy in some areas; and that due to the complex planning and infrastructure necessary for safe deliveries, maternal mortality tells us about a system's overall functioning.

Reproductive health is also historically linked to race and racialization. Especially in the United States where differences in maternal mortality between black and white women sparked (or rather renewed) a national conversation about racial disparities in health in recent years[48]. The gynecological terror unleashed on black women in the antebellum era under the pretext of medical experimentation is well documented (Washington 2006) and Dorothy Roberts (1997) has exposed the practice of coercive sterilization through Medicaid under government welfare programs as late as the 1970s. Less often cited is the work of Gertrude Fraser (2009), who

[48] According to the CDC, Black women are over three times more likely to die due to pregnancy related cause than white women (CDC 2018).

chronicled the destruction of the African American midwifery tradition and its replacement by medicalized, hospital-based births.

The "midwifery problem" Fraser describes is particularly interesting in relation to Ondo because of how epistemic practices were racialized and delegitimized in the name of modernization. in In the first half of the nineteenth century, enslaved women were the prevailing experts in obstetrics. This was a time when a care providers track record was the best gauge of their expertise (before licensing and credentialing became the measure of medical expertise). Beginning in the 1940s the craft of midwifery in the South was linked to blackness and thus "social ills" by white medical and public health professionals in other to rationalize the medicalization (and "cultural hygienization") of pregnancy care and childbirth. Fraser notes that the subsequent decline of midwifery was, for southern physicians, a measure of progress. Interestingly, in her research, Fraser finds that "midwifery and its rituals were part of a moral and spiritual set of relationships among God, the midwife, the pregnant woman, the family, and the community" (Fraser 1995, 47-48). The parallels with what I found in Ondo's relationship to birth attendants in Nigeria are striking. Still, there are further questions to be asked. What role does race play in the policies of *Abiye*? The rest of this chapter attempts to answer this question as I return to the originary moments of Safe Motherhood to examine how stories told in global health about African women can limit possibilities for intervention or worse yet, contribute to conditions that facilitate racialized violence.

Mrs. X: The Danger of the maternal death narrative

In the first session following the opening ceremony of the Safe Motherhood Conference in Nairobi, Dr. Mahmoud Fathalla presented the story of "Mrs. X," who dies during labor. The account, which Fathalla describes as "a typical profile for one of those unfortunate half a million

mothers who die every year," was first presented at an Interregional Meeting on the Prevention Maternal Mortality in Geneva in 1985. According to Fathalla, the immediate cause of death had been documented as excessive bleeding secondary to placenta previa, a condition in which the placenta sits too low in the womb. Fathalla pointed out that this condition is not fatal on its own. In a series of death reviews conducted sequentially by the hospital, a WHO-supported community-based study, a Family Health International study, and finally a study supported by the Population Council, several other causes of Mrs. X's death were discovered. These included: the four hours it took Mrs. X to get to the hospital due to a lack of emergency transport; the initial absence of the clinician upon Mrs. X's arrival delaying the start of the necessary surgical procedure by three hours; the lack of readily available blood for transfusion; unmet need in maternal health services as Mrs. X had severe anemia and a few minor bleeding episodes earlier in pregnancy (which should normally be identified in prenatal screens); Mrs. X's socioeconomic status as the "illiterate wife of a poor farmer" (1987, 2); and the fact that Mrs. X, at 39 years old with seven children, three of whom were boys, did not really want any more children." (1987, 2) Fathalla made clear that this last "cause" was meant to drive home the point that the entire saga would not have taken place had Mrs. X. had *access* to contraception to prevent her from getting pregnant in the first place. All of these factors keep Mrs. X on the perilous "road to maternal death" (1987, 4).

This case, while illuminating of several "lessons," tells us one story as if it is the only story. For Fathalla, "There is a Mrs. X dying because of pregnancy and childbirth every minute somewhere in the developing world" (1987, 1). Mrs. X, since immortalized in a short animated film (2012) in which the narrator reports plainly, "Mrs. X represents a universal mother," is Mrs. X because even the specificity of a name would have detracted from the universality of her

experience. Her story serves as meta-narrative for the maternal death narrative—a tragic story of a woman who dies during childbirth. To illustrate this point, here is another story that was presented at the 1987 Safe Motherhood conference and subsequently published in the widely distributed conference report:

> Obstructed Labour, Nigeria
>
> BOLA, 17, and her husband were farmers in a remote village. They had their own little house with no electricity, and the open field served for refuse and excreta disposal. The couple had formal education, and Bola was married at 13. Her first child was born dead after 4 days of labour. The prolonged and obstructed labour caused a hole between Bola's bladder and her vagina. The consequences of this fistula are incontinence and a persistent smell of stale urine, which make many women suffering from this injury into virtual outcasts. However, Bola had undergone reconstructive surgery, and became pregnant again two years later. Living far from a health centre she had no prenatal care.
>
> In the seventh month of her pregnancy Bola started to bleed from the vagina while carrying water home from the river. Later that day her membranes ruptured and labour started. After three days of labour without progress, Bola was taken to hospital in a state of distress, with a high temperature and pulse rate. Though the baby was small, rigid scar tissue from the fistula repair was obstructing its delivery. The baby was dead and was delivered by destructive operation in hospital. On the third day after delivery Bola was very ill. Infection of a ruptured uterus was diagnosed, but her poor condition due to undernourishment and anaemia militated against her survival. Bola realised she was

> going to die and communicated her fear and misery to the hospital staff. In spite of surgery to remove her infected uterus, Bola died in hospital. (WHO 1987, 21)

These "case histories," told in conferences, global health classrooms, and published articles, tend to follow the same course. Taking place in an often rural, unhygienic setting, an impoverished, uneducated woman who is either on either extreme of the reproductive life-span—"hyper-fertile" or barely pubescent—does not make it to the hospital on time to save her own life. The stories always feature a barely functioning health care system and almost always include a bad guy—the misogynistic husband or male figure, who is curiously at odds with the health of his wife and child (often the source of the delay in seeking care).

The women in these stories uniformly live miles and miles from the closest approved health care provider and, despite multiple previous pregnancies, have no plan in place for their deliveries. They fall into labor alone and scared, and strangely, they have no idea about any of the danger signs of pregnancy, often ignoring extremely concerning symptoms (Mrs. X ignored two episodes of bleeding earlier in her pregnancy and Bola, despite having had a prior operation, does not immediately seek care when she bleeds from the vagina at seven months). The maternal death narrative is not only demeaning in the way women are portrayed as ignorant, unclean, powerless victims of circumstance. It leaves key aspects of the story out. Where are Mrs. X's relatives and friends? Who delivered her first seven children? How did she explain the early episodes of bleeding? Who performed Bola's reconstructive surgery? Did they not tell her she was at greater risk for a ruptured uterus for her subsequent pregnancy? Bola had no prenatal care at the health center, but did she not get care from anyone else?

In her TED talk, "Danger of a Single Story" (2009), novelist Chimamanda Adichie argues, "show a people as one thing as only one thing over and over again and that is what they

become." This has personal effects, on her own subjective formation for example, and speaking about the Western portrayal of Africa as "a place of negative, of difference, of darkness," Adichie shows that the "single story" has political consequences as well. She explains how she was shocked to visit the home of the domestic worker that her family has employed: "It was impossible for me to see them as anything else but poor, Their poverty was my single story of them." She, then describes an encounter with her American college roommate, who had made similar assumptions about her before they met: "She had felt sorry for me even before she met me. My roommate had a single story for me. A single story of Africa." Taken together, these two vignettes are illuminating in a way that does more than expose stereotypes. The point is subtle. Chimamanda, a Nigerian woman, is guilty of having the same oversimplified image of maids as her roommate has of all Africans. She later contends that "this single story of Africa ultimately comes from Western literature," but I find the former reflection to be even more interesting. Yes, Africa is more diverse than "Western literature" presents it to be, but it is also important to affirm that this diversity is not harmonious. There are imbalances of power within the continent, just as they exist between continents. "Power is the ability not just to tell the story of another person but to make it the definitive story of that person."

Nolwazi Mkhwanazi (2016) points out this tendency to tell a single story in medical anthropology about sub-Saharan Africa. She finds that "the story about the unpredictability of biomedical technologies and interventions in local settings" is all too common in anthropological accounts of "medicine, health and health-seeking behavior" in Africa (2016, 194). Of the four edited volumes and one monograph that she examines, only one of the editors is African (currently living in Canada) and there is an overt dominance of authors from what she refers to as the "(global) North." Noting that medical anthropological accounts seem to singularly focus

on tragedy, she asks, "Where are the other stories—the stories that do not look into Africa but start from Africa and look out?" (195)

Mkhwanazi identifies three parts to this story: first, "the state' s lack of or inadequate involvement in the provision of health care" (2016, 195); second, "suspicion and distrust" between Africans and Euro-American countries, between Africans and their state government, or among Africans (196); and third, "the creative crafting of knowledge, meaning and action" (197) in order to emphasize that Africans are not victim. While these stories might illuminate a pressing set of issues, the danger is that even as they attempt to highlight "local agency," they run the risk of othering Africans. For Mkhwanazi, the single story is "the antithesis to anthropology, which strives to study people and their engagement with the world around them" and "endeavors to document the complexity, richness, and diversity of lives lived" (194). I wonder if the accounts do not also accurately capture an essence of anthropology that was born within the context of colonialism, an anthropology that seeks to capture, simplify, reduce, and render manageable (albeit now for scholarly consumption and global health intervention instead of colonial administration).

As Adichie notes, the problem with the single story is not that they are necessarily untrue, but that they are incomplete. Accordingly, I argue that maternal death narratives characterize the problem of maternal mortality in such a way that the solution seems obvious. It is almost as if the proposed solutions precede the narratives, reversing the sequence that scientific rationality hinges itself on. How might maternal death narratives constrain possibilities for care?

Deborah Maine, this time in collaboration with Sereen Thaddeus, wrote another landmark paper in 1994. "Too Far to Walk" is an example of how narrative, not only what story is told but how it is presented, shapes the proposed solutions. By reviewing the existing literature on

maternal mortality with "an emphasis on Africa," Maine and Thaddeus produced "a conceptual framework—three phases of delay—that identifies obstacles to the provision and utilization of high quality, timely, obstetric care" (1994, 1092). Admittedly, they limited their review to more immediate causes of maternal death, from the onset of an obstetric complication to the outcome. What they found informed their "three phases of delay" model, now commonly used to structure maternal health programs. Ondo's *Abiye* program, for example, is explicitly modeled on this approach.

The three delays described are: (1) delay in deciding to seek care; (2) delay in reaching an adequate health care facility; and (3) delay in receiving adequate care at that facility. Maine and Thaddeus offer programmatic interventions to counter the factors identified as contributing to the three phases of delay. For example, "distance" was identified as a barrier to reaching care. The options identified to address distance included having women live in maternity waiting homes near hospitals during their last weeks of pregnancy, subsidies for transportation costs to the hospital and, finally, bringing hospitals with obstetric capabilities to the most rural settings. (The authors make a brief comment on "traditional birth attendants" only to remark that training them will not solve the problem of a major complication). All three increase a specific type of access highlighted in maternal death narratives. The idea that women, some of whom have other children to care for, some of whom are in school, and some of whom are the primary breadwinners for their families, will spend the last few weeks of their pregnancy living potentially hours away from where they normally live and work seems farfetched. When women are painted only as victims, the solutions proposed do not account for the possibility that they may of their own volition say, "No."

In a presentation given by the former governor of Ondo state, "Mobilizing Resources For Achieving MDG 5: The Ondo State Example,"[49] Olusegun Mimiko summarized the phases of delays in a slide entitled, "Predisposing factors to maternal and child death." In the subsequent four slides, he described the measures that he had set in place in order to attend to these delays in the *Abiye* pilot program launched on October 28, 2009. In order to prevent delays in seeking care, "health rangers" were hired, trained, and assigned 25 pregnant women each to monitor with a customized checklist. Each woman was also given a mobile phone to communicate with their health rangers and other health providers. In response to delays in reaching care, an ambulance referral system would be set in place with speedboats for the riverine areas. Finally, delays in receiving adequate care were countered with improved facilities and the recruitment and training of health personnel.

Aside from the fact that many of these initiatives were not fully realized once the program was scaled up to the entire state, even in the pilot phase, the program left out a significant aspect of the problem of maternal mortality in Nigeria. Focused on the "three phases of delays," *Abiye* programs did not initially account for the fact that a large percentage of women (84% according to the state's own baseline survey) did not deliver in government facilities—as noted above, many of whom delivered in churches and mission homes or in the care of herbalist healers. *Abiye* could not respond to the deeply religious, mainly Pentecostal, concerns that motivate many women in their quest for successful deliveries. There was no framework, based on the stories told and models for intervention proposed, for understanding how women piece together maternal health care using multiple sources (discussed further the next chapter). It was not until an initial evaluation of the program showed that woman were still delivering outside of

[49] Based on an undated copy of the former Governor Mimiko's Power Point presentation, which was sent to me by email communication in June, 2013.

government facilities in large numbers despite renovations that the *Agbebiye*, a program which specifically addresses deliveries at home and in churches (discussed further in Chapter Five), was added to *Abiye*. Imagine what might have been included at the pilot phase had the maternal death narratives that informed the three delays models included a diversity of women's experiences?

With conditions as described in maternal death narratives, it is a wonder any African woman is able to delivery successfully. Rarely do informal birth attendants make it into these stories. If they do, they are at best supporting characters with no lines and at worst, the very reason for the delay in seeking care. Maternal death narratives do not show communities coming together or sisters, mothers-in-law, and church congregations pooling their resources to ensure a safe delivery. They don't discuss university students visiting mission homes, or how a woman who has been deemed infertile might take over-the-counter hormones to induce a pregnancy. Where are the stories of women who successfully abort using drugs given to them by a friend of the family—women who use the wisdom in their networks to manage happy and healthy pregnancies?

In the remake of Fathalla's original video, "Why did Mrs. X die (Retold)" (2012), the narrator introduces the film by explaining that since Fathalla's original lecture in 1987, "in some places, things have hardly changed. Women and their babies are still dying needlessly. This is why the story of Mrs. X must be retold." Rather than looking for new ways to illuminate the problem of maternal mortality, the same stories are literally retold again and again. In light of the lack of progress made since 1987, it is time to tell new stories that reflect the diversity and depth of African women's experiences in relation to childbirth.

A balance of stories

I used to work at a salon. I was learning to become a hairdresser. In that place, we used to do [prayer] meetings with those who were the leaders there, we had meetings together with them. A day came when we were praying and praying. Whenever I would go there, they would always call me, "Mommy, mommy, mommy" We always had fun together. On that that day, the Holy Spirit took hold of one person in a shop and said that God called me, that I was not paying attention well. The truth is when I was working, I spent more than seven years working without making any money. I was borrowing money to use to buy things, to buy [hair accessories] to sell in the shop without success. I was- I was just doing it. Sometime later, a prophet came to our place to tell me. I said, "Would God call someone like me? What does He want to do with someone like me? When there are people who are very close to Jesus, would He call someone like me?" He said that it does not matter. So, that [evangelist] said that I should go pray, I should go fast for three days, that whatever I saw then, I should tell him. He said that I should not do it in church nor in my house, that I should go to the bush where I would not be able to see anyone. I just said, "Thank you."

Inside the bush where I was, I saw eight birds. They came to me. They came in front of me. Small, small birds. They were in front of me. Ah! Inside the bush, me alone at midnight! How will I survive? I tried to pray. I was crying. I was praying. I had a fearful mind and with it I was praying. I was praying. As the day broke the following day, I was going home. The first person that I encountered, that Spirit said, "Go back. You are going nowhere. You cannot see in front of you and you will not see unless you go back." I did not know the way again that afternoon- that morning. There was no way in front of me again unless until I turned back. I said, "Jesus, save

me!" I went back into that bush. Some other people were passing too. I was shouting, not praying, not crying. We were going. They stopped. They asked me what I was doing there. They saw me, the way I was. They said they wanted to take me home, but there was no way to get back home. I then said, it's okay, to those that wanted to take me home. I said that they should go, that they should let me use my own to- if there is something that happens that kills me in the bush here, let it come and kill and God will take care of my children.

I tried very very hard. I spent the three days in the bush. The birds did not leave the place where they perched until I finished fasting fast three days. When I finished, I was going and the birds were following, those small, small birds. They followed behind me. So I went first to the house of the pastor that told me to fast directly because I could not walk anymore. I was doing like this [bent over, tired]. The pastor asked me what I saw. I said, "I saw birds." He said, "Yes." He said those birds that I saw represent the babies that I was supposed to have delivered, that they told me about, but I refused. He said that God turned them into birds so that they can stay with me. He asked me what else I saw. I explained what happened to him. He said that I wouldn't be able to find my way back. He said that those children would not allow me to find my way until I do the work that I was supposed to do. He said that where I was supposed to go, I did not go. I said, "Okay, but I don't have anybody to sponsor me in school." He said if I stand up to take the call, God will do it. I said, "Okay." The pastor brought the form for me here.

*

This section interrogates the theoretical and empirical potential of "a balance of stories," as Chinua Achebe describes in an interview, which I quote here at length:

> This tradition that I'm talking about has been in force for hundreds of years…What was preached in the churches by the missionaries and their agents at home all supported a certain view of Africa. When a tradition gathers enough strength to go on for centuries, you don't just turn it off one day. When the African response began, I think there was an immediate pause on the European side, as if they were saying, Okay, we'll stop telling this story, because we see there's another story. But after a while there's a certain beginning again, not quite a return but something like a reaction to the African story that cannot, of course, ever go as far as the original tradition that the Africans are responding to. There's a reaction to a reaction, and there will be a further reaction to that. And I think that's the way it will go, until what I call a balance of stories is secured…where every people will be able to contribute to a definition of themselves, where we are not victims of other people's accounts. This is not to say that nobody should write about anybody else—I think they should, but those that have been written about should also participate in the making of these stories (Fetters 2003).

How can a balance of stories be achieved? What are the alternative to maternal death narratives? Following the literary turn in anthropology, inspired by feminist anthropology and immortalized in *Writing Culture* (1986), I am, like many, concerned with the literariness – its quality of being something fashioned – of ethnographic writing and relations of power embedded within. But also intrigued by what is made possible. The now uneasy relationship between social scientific text and fact allows literature to enhance anthropological inquiry as illustrative of forms of life, but more effectively as theory. Zora Neale Hurston, as anthropologist and writer, is emblematic of in this regard. She offered an answer to the space of uncertainty generated by the literary turn decades before it. Hurston's unique methodological approach entailed the production of

authentic, untranslated portrayals of black folklore and culture. She consciously used both the first-person accounts of *Mules and Men* and fictionalized drama of *Their Eyes are Watching God* to challenge prevailing representations of black women and explore relationships between black men and women in the South. Her description of the "toe-party" in *Mules and Men*, for example, layers the play of dance party over memories of the slave auction in ways that simultaneously expose the male gaze, the objectification of black women, and sinful pleasure.

Similarly, as I have shown in Chapter One, African women's literature and literary criticism opens up space for a new analytical lens through which representations of motherhood and African women can be complicated along with the possibilities for maternal health care. Theories on motherhood in much of White feminist scholarship have been insufficient. Dorothy Roberts (1992) argues that the social construction of motherhood in the United States leads to the stigmatization of mothers who do not fit this mold. Black women feel the intersecting effects of racism and patriarchy, which must be confronted together to understand the impact on the lives of black women. Ogunyemi borrows the concept of "vernacular theory" from Houston Baker and Henry Louis Gates as she examines myths in order "to generate a sophisticated reading of Nigerian women's texts" (Ogunyemi 1996, 20). Her own "woman-centered vernacular theory" allows for a different conception of motherhood than that of the "cult of domesticity," against which much of white feminism is formulated (see Friedan 1963).

Ogunyemi examines the myths of the Yorùbá water *òrìṣà*, Òṣun , as mode of exploring motherhood. "Every woman's story is a variation of this crucial tale," she explains (Ogunyemi 1996, 26). In one of many versions that circulate about Òṣun , she is the sole female among seventeen male *òrìṣà* tasked by Olodumare, the supreme presence, to establish the world. After a dispute with the other *òrìṣà*—which Ogunyemi hypothesizes may have been rape—Òṣun

withdraws from the world, taking with her a necessity for life, rainfall. The male *òrìṣà* appeal to Olodumare to reason with Òṣun , and Òṣun , who has become pregnant, agrees that if only she produces a male she will return and attempt once again to live harmoniously with her brother *òrìṣà*, but if her offspring is female she will have even more reason to remain in isolation. The fate of the world is in her womb. With the birth of a male child, Esu, who will become a cunning mediator, the conflict is tenuously resolved. Òṣun , ancestral mother, has saved the world.

Following Hurston, as well as Nancy Rose Hunt (1999), I offered a first-person account to begin this section. Itunu was a student at the CAC faith home in Odo Owa, a small town in Kwara state, just north of Ondo. I interviewed her and several of her fellow birth attendants in training over the course of an afternoon during in late Harmattan 2016. Itunu experiences attending births as answering a call from God. During the time she ignored it, there was no harmony in her life. It is only after a retreat to nature that she returns reborn into the world. She like Òṣun will guide women into motherhood, protect their fertility, and foster wellness. The fit with the myth of Òṣun is not perfect, but that is not the point. Here again is the "creative motherhood" that Chikwenye Ogunyemi (1996) finds in Efuru's turn toward Uhamiri (1996, 153; see Chapter One in this text).

Beyond afro-pessimism

In this chapter, so far I have examined how processes of knowledge (re)production structure possibilities for care, and likewise lived experience. To close, I comment on an emergent and provocative field of discourse in critical race studies. Where pessimism about Africa—portrayals of the "dark continent" as tragically doomed in relation to its problems of poverty, corruption, violence, and poor health—is short-sighted, failing to consider legacies of imperialism, racism, and exploitation; the set of theoretical understandings that have come to be known as

afropessimism exposes the ongoing effects of these processes and posits black existence as the negativity against which whiteness, freedom, and liberalism is defined. While encompassing a wide range of critical thinkers, afropessimism has come together as an analytic that illuminates the legacy and elaboration of global white supremacy by positing anti-blackness not simply as a consequence of modernity but at the core of its very possibility. These concerns are pertinent in relation to contemporary configurations and logics of global health, where the ethical injunction to care can be read alongside a long history of colonial intervention of which anti-blackness was at its liberal-humanitarian core. But what is obscured in afropessimism's unrelenting emphasis on social death and irrecuperable destruction?

Hortense Spiller's landmark essay, "Mama's Baby, Papa's Maybe: An American Grammar Book," a response to the notorious 1965 Moynihan Report, is often cited among afropessimistic theorists but her work is also about the power of language and the way narrative shapes experience. The process of taking Africans from their homes and transporting them across the Atlantic is objectifying in itself. African bodies are forced into slave ships and arrive in the Americas as "flesh," or "that zero degree or social conceptualization" Among the uses of "female flesh," is medical experimentation, as described by William Goodell in 1853 but a phenomenon that can be traced to the contemporary moment as noted above. Even though the captive is now free the epistemic frameworks set in motion during slavery "dominate symbolic activity…grounded in the originating metaphor or captivity and mutilation" (Spillers 1987, 67). All perceived difference is made hierarchical.

How might we see Mrs. X in light of these legacies of race and racialization? Jemima Pierre bemoans the lack of racial analysis in the contemporary study of Africa and calls for Africanist scholar to engage "the complex ways that race continues to be significant in this

postcolonial moment" (Pierre 2013, 548). Racial legacies of European hegemony and white supremacy are especially important for health care in postcolonial settings. Maternal death narratives are examples of how global racialized and gendered hierarchies operate in global health and humanitarian regimes. However I worry that afropessimism and the single story are dangerous in similar ways. Positing blackness as existentially non-human tells a single story, which starts with the violence of the trans-Atlantic slave trade and masks the varieties of forms of life that precede it.

If we are asked routinely to think with a certain African death, through global health calls, through media representations, through some critical theory, perhaps we make a "darkness" that has only one register, making the multiplicity (and ambivalence) of existing alternate modes of life unthinkable. Maternal death narratives obscure the plethora of ways that women have, in fact, survived, the lengths that women (and I add men) go to in order to ensure safety for themselves and their children. I choose the analytic of survival (rather than maternal health, for example) because it is not quite the inverse of death. Survival allows for the plurality of alternate modes of living that a concentration on death renders into singularity. In survival, we recognize the journey, the ordeal, suffering, pain, and disability along with the instances of everyday ingenuity, creativity, and joy surrounding childbirth.

Chapter Four
Having Faith, Collecting Care: Logics and logistics of maternal survival

A new mother is greeted with, "*ẹ kú ewu ọmọ*" in Yorùbáland. She is congratulated for surviving the dangers [*ewu*] inherent in bringing a child [*ọmọ*] into the world regardless of the particulars of her own delivery day. The stakes of the moment have never been lost on the woman and her loved ones, but this is also often the first moment that the risks associated with her childbirth are acknowledged aloud. To speak of them before the potential perils have passed, before the baby has cried and the placenta has been removed, is to give substance to an otherwise not yet formed essence. Here, I hesitate to even call it a possibility. It is there. Everyone knows it is there, but for the pregnant woman in question, it cannot even be called a possibility. The doubt that this type of utterance would introduce bears on the outcome. As Raymond Ogunade (2009, 2) writes on faith in Yorùbá religious traditions, "the quality of your expectation or result depends on the faith you have from the beginning" and "your confidence (faith)…will determine the type of result you get."

For these women, the risks of pregnancy can only be elaborated in the abstract. There is a story known in Yorùbá circles (and perhaps other Nigerian ethnic groups), which likens pregnancy to the journey women would take to procure water for daily use. In the story, there are three women carrying pots to collect water from a nearby stream. While the trip to the stream with the empty pots is relatively easy, the way back is more difficult due to the added weight of the water. In the story, the first woman slips. The pot falls from her hands, breaking into pieces, and the water spills out. This is an instance of maternal and infant death. The second woman also slips, but she grasps the pot tightly so that only the water is lost. Her fate represents women who have had a miscarriage or stillborn child. A common Yorùbá consolation is derived from this

part of the story: "*Omi ló dànù, ìkòkò kò fọ́"* [The water has spilled, but the pot is not broken]. This is to say that one should be thankful because despite the infant's death, the woman is still "complete." Complete in that her womb, represented by the pot, is unbroken, and she can therefore have other children. But also, perhaps complete *because* she can have other children. Again here, womanhood is tied to the potential for motherhood, a point I will continue to return to as it turns childbirth into a necessary subject-forming event for womanhood. For now, it is important to note that there is no scenario in this story for the woman whose pot breaks—that is her womb becomes unable to bear children—and still lives. Is this a tragedy too terrible even in abstract? Is there no woman after her womb? Returning to the conclusion of the parable, the third woman moves adeptly along the treacherous path and makes it home with her pot still brimming with water. She has had a successful delivery; she and her child are alive. Her journey is the subject of this chapter.

As we saw in the previous chapter, maternal death narratives – tragic stories of women dying during childbirth – are some of the most widely circulated representations of African women. In this chapter, I explore what we have to gain from focusing on narratives of maternal *survival*. In concentrating on the pathways to death, these narratives have ignored the plethora of ways that women have in fact survived, the lengths that women go to in order to ensure safety for themselves and their children. I choose the analytic of survival (rather than maternal health, for example) because it is not quite the inverse of death. Survival allows for the plurality of alternate modes of living that a concentration on death would renders into singularity. In survival, we recognize the journey, the ordeal, suffering, pain, and disability along with the instances of everyday ingenuity, creativity, and joy surrounding childbirth. Maternal death

narratives not only creates this problem of representation; they also limits the proposed solutions to maternal mortality. The challenge lives out the prophesy of intractability.

What do some Nigerian women do in order to make it back from the river with their pot intact and filled with water? How do they interact with the multifaceted and intersecting systems of formal and informal maternal healthcare in Nigeria? While living in the state of Ondo, in southwest Nigeria, I traveled with pregnant women in and out of various sites of care as diverse as biomedical hospitals, churches, private clinics, and the homes of community healers. What became apparent was how important it was for women to demonstrate a faith that required a vigilant denial of the possibility that things can go wrong, what Ogunade equates with "confidence" (2009, 2). At the same time, women spent a great deal of time piecing together different sources of care in an effort to ensure successful deliveries. This tension – between "collecting care" and "having faith" – is central to the negotiations women make as they navigate through networks of care. It also points to the continued relevance and transformative power of religion in the lives of Nigerian women.

This chapter draws force from three scenes, moments in the antenatal experiences of three pregnant women that I met while shuffling back and forth between Ondo's newly built public hospital, Mother and Child Hospital and a Christ Apostolic Church mission home nearby, two institutions with opposing logics of care that are nevertheless intertwined as I will show. While I will focus on movement between these two spaces, the array of options available to women is expansive and warrants a somewhat brief unpacking before introducing the three scenes.

Apart from public hospitals, staffed by government-licensed doctors, nurses and midwives, there is a vast terrain of private practitioners offering diverse forms of care in both

rural and urban Nigeria. As I have touched on in earlier chapters, a long colonial history of church involvement in the provision of maternity care (Chapter Two) coupled with postcolonial intervention in the form of structural adjustment programming (Chapter Three) has contributed to a situation in which medical authority is both decentralized and fluid. Take, for example, mission homes. There are official mission homes sanctioned by churches, the most infamous being those affiliated with the Christ Apostolic Church (CAC), that exist at odds with biomedical practice. There are also other official mission homes, like that of Redeemed Christian Church of God (RCCG), that welcome biomedicine but only in conjunction with prayer. Finally, there are unofficial mission homes that may be affiliated with a given CAC or other Pentecostal church, but have not been formally recognized by church headquarters. Birth attendants in any of these settings may or may not check blood pressures or test urine at prenatal meetings, but all mission homes perform some version of an abdominal exam and most tend to listen for fetal heart sounds with a fetoscope.

It can be hard to distinguish the last category of unaffiliated mission home birth attendant from other *community birth attendant*s. Community birth attendants may operate out of their homes or in a borrowed space (at a church, for example). They have been trained in a sort of apprenticeship setting, perhaps in a local private hospital or by another community birth attendant. One woman I spoke to had been called by God in a dream to do the work of attending births. She told me she had not been trained by anyone, but instead she had had dreams telling her how to attend deliveries. These attendants usually pray for the woman who come to them much like mission home birth attendants, but some also offer *agbo*, medicinal herbal concoctions, depending on if the woman has a particular complaint. This herbalist knowledge is based in Yorùbá religious traditions and often passed down from practitioner to practitioner in an

intergenerational manner. Herbalists, diviners, oracle consultants, bone setters, birth attendants and other spiritual healers can apply for membership to Natural Traditional Medicine Practitioners (NATRAMP), a highly organized national association with state and local chapters.

Private biomedical hospitals also exist. Licensed doctors, discouraged by salaries that are meager and sometimes not paid at all, open up their own practices where they set their own fees. [50] In Lagos, these hospitals tend to have newer equipment and are accessible to only the richer portions of the population. In more rural Ondo, private hospitals vary in quality and are far more affordable. Many of these private hospitals charge cash up-front and offer a la carte services. For an ultrasound scan, for example, a pregnant woman might be charged about 1000 Naira (USD $3) in Ondo. They also bring in additional revenue by offering certificates in auxiliary nursing to those who pay to work for them for one or two years, learning the trade along the way. The providers that finish this type of training remain unlicensed in the eyes of the state, but they use their certificates to open up their own private practices. Private providers have their own umbrella organization, Association of General and Private Medical Practitioners of Nigeria (AGPMPN), also with state and local branches.

Finally, while international agencies tend not to offer direct care in Nigeria, preferring to exercise their influence through other means, the detection and treatment of HIV/AIDS has been a notable exception.[51] Pregnant women living with HIV may receive at least a portion of their

[50] The Medical and Dental Council of Nigeria (MDCN) is the regulatory body responsible for the licensing of all physicians in Nigeria. Physicians can apply for a license after graduation from medical school and completion of one year of internship at a hospital. Interestingly, they also give licenses in the category of *alternative medical practitioners*, which are a category considered to be separate from *traditional medical practitioners* (although one can see the lines quickly blurring). Alternative medical practitioners can register for a license in the areas of acupuncture, naturopathy, homeopathy, or osteopathy, but it is not entirely clear how their training is evaluated.
[51] Most recently, many international agencies are making investments in "health systems strengthening" with interventions oriented around "performance-based financing" in an attempt to work toward "universal health coverage." See, Tichenor and Sridhar (2017) and Paul et al. (2018) for discussions of these recent trends in global health intervention. At the same time, the role of the private sector continues to be acknowledged and supported

care from international NGOs. Even in Nigeria, where HIV rates are comparatively lower than they are in some southern African countries, the exceptionalism of HIV transmission and treatment has had a profound effect on the care of pregnant women. On one of my first visits to pregnancy prayer meeting at a mission home, I was completely caught off guard when a woman from an HIV NGO arrived in the middle of prayers. She briefly explained the test to the pregnant women in Yorùbá and proceeded to test each one of them with rapid test strips. Remarkably, her visit was neither a surprise nor experienced as incongruous by anyone else.

The challenge of making sense of the maternal health landscape in Ondo is one of rendering complexity without resorting to an image of chaos, striving for clarity without distortion. My initial instinct was to drop the reader into the thick of it without much of an introduction, but this seemed overly and unnecessarily disorienting. While I have opted to give more by way of explanation, the array of options with which women are presented do not come with neat labels, and even my own characterizations should be cautiously received.[52] Storefronts transform into faith-healing churches, "doctors" are not always licensed physicians, prenatal pills come in unmarked plastic bags, and hidden costs of care appear at the most inopportune moments. At the same time, the skill with which many women navigate this uneven terrain, without official shepherding, is masterful. In what follows, I present more of this nuance, gathered from accompanying women as they carried their water-filled pots back from the stream.

internationally. Nigeria State Health Investment Project (NSHIP), a World Bank-assisted project, recently granted 12 million Naira in aid to eight private hospitals in Ondo with plans to expand this scheme in the future.

[52] Veena Das (2015) discusses a similar phenomenon in North India in Chapter 6, "Medicines, Market, and Healing" of *Affliction*.

Faith and care in three scenes

Overture

On a Sunday afternoon in August of 2015, the traffic in Akure clears, revealing mostly paved roads lined with open gutters. A rare okada driver putters by, transporting men in dark suits who clutch bibles to their chests. Along the road leading up to the recently built Mother and Child Hospital, the roadside stands, normally bustling with street hawkers and market women advertising their wares from tiny red peppers to flat screen TVs, have become empty wooden shells. Mother and Child Hospital (MCH), on its large walled-off plot, towers imposingly over these lower-lying makeshift stalls. Inside, as visibly pregnant women sit on wooden benches arranged like pews, waiting to have their babies delivered by a small group of nurses and doctors in white or pastel-colored linens, music from the small Pentecostal church nearby drifts in: lyrics of praise reinforced by drums, tambourines, a guitar and a keyboard. The hospital and this church, the *Ile Abiye* branch of CAC, are among the few spaces alive with activity on a Sunday.

At times the reverberations between church and hospital can be striking. The hospital walls vibrate with the hum of an impassionate communal prayer coming from *Ile Abiye* church next door. The clicking monosyllables of those speaking in tongues keep time for the layered rumble of thunderous voices praying. Occasionally, a deafening high-pitched cry is heard. It is difficult to discern whether the cry comes from a woman on the verge of giving birth or from a woman collapsing in the ecstasy of the Lord.

One

On Mondays and Thursdays, the large front hall of MCH, a government hospital in Akure, Ondo's capital, is filled with over one hundred pregnant women. They file in around noon and sit in lines of bright blue, yellow, and orange colored chairs as they wait for the week's follow-up

antenatal program to begin. On a Thursday in November 2015, a grainy film is shown on a TV screen hoisted up in the front corner of the room. The film describes the dangers of pregnancy, which include, among other potential outcomes, "infection" and "ruptured uterus." At the end of the film, the narrator implores the women to consider all of the possible dangers before choosing where they will deliver. He states that what matters most is not where you go for prenatal health talks, but where you ultimately choose to deliver. The film ends with a prayer, *Ẹ kò ní bòyún kú* [*You will not die with pregnancy*], to which the expecting women answer out loud, "Amen." The words, *GLORY BE TO GOD,* in bold white letters against a black background serve as the final image of the film.

A psychologist, affectionately known as *Ọkọ Olóyún* [husband of pregnant women], then takes the stage. In khaki trousers and pressed collared shirt, he greets the pregnant women by predicting the fortunes of their children, and they respond enthusiastically:

"Ìyá Àbíyè" [Mother of children who survive birth]	"Yes o"
"Ìyá Lawyer"	"Yes o"
"Ìyá Senator"	"Yes o"
"Ìyá Doctor"	"Yes o"

Next, Ọkọ Olóyún leads them in prayer followed by a series of songs. He begins by asking the women to stand up straight like members of the military, not like civilians. He marches in place, encouraging them to the do the same as they sing:

Mu mi bí wẹ́rẹ́ o Olúwa	[Help me to deliver safely, Lord]
Mu mi bí wẹ́rẹ́ o Ẹlẹda mi	[Help me to deliver safely, My Creator]
K'a gbọhun mi k'a gbọ t'ọmọ	[May we hear my voice and that of the baby]
L'ọjọ ìkúnlè	[On the day of delivery]

Ọkọ Olóyún leads them from song to song, and the once-still room is alive with women dancing, singing and clapping, attempting to call into existence their own successful births. A health talk follows. The day's topic is avoiding "deep thought" or stress in pregnancy, but on other days, topics range from healthy diets to how to care for a newborn to warning signs in pregnancy. Always, regardless of the day, Ọkọ Olóyún and his nurse colleagues warn the women against receiving care from anywhere outside of the hospital. No concoctions from herbalists. No off-label drugs from private pharmacists. And no delivering in churches.

Among the attendees is Tolu, a woman I originally met a few weeks earlier at the CAC-*Ile Abiye* church nearby. In addition to registering her pregnancy at MCH, she has also registered at CAC-*Ile Abiye* mission home, where she regularly attends weekly pregnancy prayer meetings held on Tuesday mornings.

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That Tolu had registered at both the mission home and MCH was so natural to her that she had trouble explaining it to me. She is one of many women who effortlessly cross the boundaries set up between church and hospital in search of pregnancy care. These boundaries are discursive as much as they are material. The message in the hospital is meant to be clear: Do not go elsewhere for care, as the care in other spaces is ineffective. We hear this in the film that is shown (although the film is more explicit about site of delivery) and in the health talks that the women are made to listen to before they are seen for their antenatal check-up. However, this health education and the medical examination (blood pressure, weight check, abdominal exam) only come after sometimes up to an hour of prayer, singing, dancing. The hospital is more porous than it would seem. Even the film ends with a prayer. The women are encouraged to claim their successful deliveries, call them into existence in much the same way they would at church. At

MCH, faith is given equal space to operate as the biomedical interventions that come later. Or perhaps, all care, regardless of where or how it is delivered, demands faith first. Even for the care providers at MCH, the transformative process that is healing cannot be completed without it.

Two

While the space where the women will give birth is a crowded trailer next door, the weekly pregnancy prayer meetings are held in the CAC-*Ile Abiye* church itself, a large hollowed cement building with high ceilings and the impression of wooden rafters. On Tuesdays, pregnant women arrive early in the morning, pick up brightly marbled plastic buckets and literally walk across an abandoned field to collect water (reminiscent of the way women fetch water in the allegory above) from a well that will later be sanctified and used for bathing. When they return, they are met by the matron of the mission home. Known to the women as Mama Àbíyè, she is an elderly woman, always elaborately adorned in intricate lace blouses and wrappers. A younger woman, Mama David, who Mama Àbíyè has been grooming to take her place when the time comes, is also present along with a pastor from the church.

On an especially dry January morning in 2016, one woman kneels at the altar, praying audibly for her family and occasionally breaking into praise song as two other women leave to get their well water for the day. Mama David rings a bell to start the meeting. The women take turns leading praise and worship songs that they all seem to know by heart. Next, prayer and testimony are interwoven with pregnancy teaching by Mama David. The women are told stories about other women who did not have faith in their God, who chose to go to the hospital and wound up being forced to have Caesarian sections. She reminds the women that they should never stray too far from the church during pregnancy before transitioning into a series of what are called *prayer points* for the women to keep in mind while praying. After each prayer point,

the women erupt into a complex layered rumble of voices. Some with eyes closed, others rocking vigorously in place with clenched fists. One woman paces between the white plastic chairs with her hands extended above her head.

Lord, give me the power of the Holy Spirit so I may be strong when I delivery my baby.

Lord, destroy every watchful evil spirit over my life, and all eyes that see my pregnancy, let them also see me carrying my baby.

Prayer is interrupted briefly when Mama David receives a phone call. Afterward, she informs the pregnant women that the call was from Seyi, a woman we all knew from previous prayer meetings. Seyi had been having difficulty during her pregnancy ("her whole body was swollen") so she had gone to MCH, where she had stayed for a couple weeks before being sent home. Now, she was again admitted at MCH, having recently delivered there. She had called to say that ever since the delivery, she had been unable to walk or even move her legs at all. She was requesting that Mama David talk her mom into transporting her back to the church for prayers. Mama David refused. Seyi had brought this upon herself. She would not be allowed back to the church. She had not completed her three days fasting as prescribed by the prophet multiple times. She would either refuse or reply that her mother would do it on her behalf. She was always the last to arrive to prayer meetings and the first to go. In general, she did not take prayer seriously enough. The other pregnant women present listen in silence, and Mama David seamlessly continues with the prayer points.

Lord, give me success in this mission home and do not allow a nylon bag to take glory over my pregnancy.

Lord, renew your miraculous power in the life of Mama Àbíyè so that she will not work in vain and with the pregnant women, she will not have any problem.

Lord, remember the barren that are looking up to you for the fruit of the womb and answer their prayers too.

And finally:

Tell God what you want to see on your delivery day.

Now it is time for members to give testimony. One woman, Ope, who delivered at the mission home a month ago has arrived with her tiny baby strapped to her back with two layers of fuzzy blankets and two boxes of biscuits to offer the group. Mama David unties the baby and gives him to Mama Àbíyè, who holds him bundled in the thick bright orange striped fabric that she had had wrapped around her waist while Ope gives testimony of her delivery. She thanks God and Mama Àbíyè, who delivered her, and recounts that she, too, had been unable to move her legs immediately after delivering. They had felt "dead and heavy." At the end, God took control. She walks today because of the prayers of Mama Àbíyè, which God answered. Her testimony is peppered with praise songs and also interpreted by another pregnant woman who is moved to sing a song on her behalf. At one point, she drops to the floor and begins slowly rolling back and forth, her arms delicately outstretched at awkward angles. It is not quite as if she is possessed but as if she has no other choice but to do so, no other way to show her gratitude to the Lord.

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Seyi, like Tolu, had registered her pregnancy at both MCH and the mission home, but when it came time to deliver she went to MCH, perhaps because she felt her complaints were beyond the expertise of Mama Àbíyè. Still despite having delivered at the hospital, she called the mission home to ask them to pray for her. She felt that this was something that might help her situation, that the mission home could offer her something the doctors at MCH were unable to accomplish. Even if the circumstances around Seyi's delivery at MCH are not entirely clear, we can learn something from the way her story was told at the mission home. Mama David, Mama Àbíyè, and

the pastor framed the misfortune that had befallen Seyi as the result of her not taking prayer seriously. Her mistake was not necessarily going to the hospital (although all three had on several occasions preached the possible dangers that awaited women at the hospital). Rather, she did not have faith. Faith, in this instance, is not simply confidence that the delivery will go well. It is a confidence in God's role in the delivery, which she had forsaken by choosing not to pray. Ope, by contrast, had demonstrated her faith. Though there were obstacles, she and the other pregnant women believed that it was her faith and dedication that had made her delivery successful in the end.

Three

At prayer meetings, Funmi stands out. She has both a small boy tied to her back balanced in the front by impossibly large rounded belly. She often volunteers to lead the praise and worship songs with which each session begins. On one Tuesday in June, Mama David proudly pointed to Funmi and told us that though her husband is a doctor, she still chooses to come to CAC. "You see, we are not all uneducated," she said to me. "Some of us are lawyers and doctors who *choose* to come." The teaching for that day was on the Holy Spirit. Mama David told the pregnant women that it is the Holy Spirit that enters us and guides us. "Maybe you wake up one morning and decide to take one taxi instead of another, and then later you hear that there was an accident with that very taxi that you decided not to take. That is the Holy Spirit guiding us. Now, let's pray so that the Holy Spirit will guide us in everything that we do and prevent us from taking the wrong path."

It is six weeks later and rainy season is coming to an end. Funmi has delivered at the mission home. She had a second baby boy, but it is bittersweet. Her husband had been trying to persuade her not to deliver in the mission home, but she was convinced that it was his lack of

faith that caused her to deliver a stillborn during her first pregnancy. When a neighbor brought her to the mission home for her second pregnancy, which had produced the boy tied to her back, her husband had been angry, asking why she would go to such a "local environment." Her second pregnancy having been successful at the mission home, she had planned to deliver her third there as well.

Her husband, it turns out, was not a medical doctor, but a private provider, an auxiliary nurse, who had possibly undergone some form of apprenticeship before opening up his own practice in his home. He, like a lot of other entrepreneurial healers, had come to be called a doctor by the people who knew him. The word in Yorùbá, *onísègùn* [doctor] does not distinguish between types of certifications.[53] Nevertheless, he cared for pregnant women in his own place and was appalled that his wife would be "so ignorant" as to choose to deliver in a church. He blamed the church for his wife's previous stillborn.

In the face of Funmi's continued births at the mission home, her husband never abandoned his stance as a skeptic. It also turns out, he was a cultist. In the end, he had told his wife that he was going to travel, but really locked himself in a room in their house that Funmi had never been allowed to enter. When Funmi returned home from church one day, she heard some noise coming from the locked room so she forced it open. There she found her husband dead, naked and surrounded by a set of items that to Funmi, Mama David, and the neighbors could only signify one thing. A bottle of Jik bleach, a bottle of schnapps, a dead hen, and a dead cock all pointed to the husband being a cultist.

In our length discussion of what had transpired, Mama David says he had been doing a ritual likely to harm Funmi, but fortunately the Holy Spirit had protected her. Just a few days

[53] Although some might specify *onísègùn òyìnbó* as opposed to *onísègùn ìbílẹ̀* to distinguish between a doctor who uses "Western" medicine and one who practices "traditional" medicine.

before this incident Mama Àbíyè had called Funmi to the church for a special three-day vigil during which everyone prayed for her. This had protected her and the husband's attempts at evil had been thwarted. Mama David reminds the women that this is why we must always ask the Holy Spirit to guide us. Later, during prayer, a baby chick wanders into the church. It causes such a distraction that all three, Mama Àbíyè, Mama David, and the pastor, work together to chase it out.

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The discovery of Funmi's husband's clandestine activities illustrates the haziness through which women must navigate their sources of care. At first, Mama David attempted to legitimize the medical authority of the mission home by mentioning that Funmi's husband was a doctor. Mama David was well aware of the stereotypes of women who choose to attend mission homes: that they are poor and uneducated. Funmi, being a doctor's wife and still choosing to come the mission home both worked against these negative conceptions of mission homes and added legitimacy to their work. Especially in my presence, but I think also for the women in attendance, it was important for Mama David to demonstrate this legitimacy in concrete ways. On one occasion, Mama Àbíyè showed me the certificate she had received from her training at the CAC maternity school in Ede.

When Funmi's husband was found dead surrounded by ritual artifacts, the story evolved and he was stripped of his medical authority, demoted to an auxiliary nurse. Auxiliary nurses are unlicensed and not legally authorized to practice on their own, but they theoretically have been trained in biomedicine by a licensed medical provider. As the story unfolded, we learned that this likely was not the precise case either. In news reports of the man's death, a neighbor claimed that he had been "engaging in illicit ventures in the house, which he converted to an illegal hospital,

performing abortions for young ladies." There is something about the way he operates between worlds that makes his actions particularly scandalous. He is not simply a cultist, but a cultist operating as if he were a doctor, or at the very least, answering to the title. There is also a distinction here made between occult spirituality and that of the mission home. Just as MCH attempts to draw a line between their work and that of the mission home, the mission home is invested in separating themselves from something that resembles Yorùbá religious tradition. The boundaries, however, are made porous by continuities in care and faith, allowing the women to move through various traditions, attempting to collect the elements that will lead to successful deliveries.

Thinking about the verb "gbàgbọ́"

The words faith, belief, and Christianity, are all translated into the same word in Yorùbá: *igbàgbọ́*. There is no way of distinguishing between the three potential senses of the word without context. Likewise, *gbàgbọ́* is translated into English as the verb, "to believe" or "to have faith." It is the result of a compounding of the words, *gbà* [to receive/take/accept] and *gbọ́* [to hear]. A believer or a Christian (both translated as the same word, *onígbàgbọ́*), then, is someone who has accepted what they have heard. One can imagine an early Christian missionary trying to "give" a Yorùbá person the message of God with variable success. There might have been those who took what they heard (*onígbàgbọ́)* and those who did not take what they heard *(alaígbàgbọ́* [translated as nonbelievers or infidels]). Though it must remain speculation at the moment, the suggestion is that the concept underlying the set of words surrounding belief was introduced at the same time as Christianity.[54] What implications does this have for the way we understand faith and belief in Nigeria?

[54] Though this seems like a safe assumption, it would be difficult to know for sure given that the first attempts to standardize written Yorùbá were spearheaded by English missionaries with a bulk of the work, including a

For Jean Pouillon (1979), there is an ambiguity expressed by the verb, to believe. Within the assurance it expresses, it also reveals a doubt. But this paradox, he clarifies, is only pertinent to worldviews that make the distinction between "un monde naturel et un monde surnaturel…un 'ici-bas' et un 'au-delà'" [a natural world and a supernatural world…a 'here below' and a 'beyond'"] (1979, 44). It is this distinction that provides the conditions for the distance that exists between belief as representation and belief as faith for Christians, or rather Pouillon's Christians. The Christianity he describes is so predicated on this distinction that it requires one word that links doubt with conviction. These Christians are always simultaneously expressing their faith in God, their belief in God's existence, and their belief that God has certain features (1979, 48). The reasons for this are multifold but above all rely on the historicism of Christianity—the way Christianity draws on a particular historicist temporality of Christianity.

Pouillon argues, in his comparison of Christianity with the religious tradition practiced by that of the Dangaleat of Chad, that unlike the Dangaleat, Christians must contend with the existence of other beliefs that are not only outside of their own but predate it. Christianity, thus, is always constituted against other systems of belief. Further the distinction between worlds, itself, offers a challenge to the Christian believer. They must both believe in the world of the Creator and their own which follows a set of laws which are entirely knowable in contrast to the world they can only believe in (as opposed to know). Pouillon writes:

> [The Christian] knows—it is even an essential point in his *credo*—that the object of his belief is in a "reality" of a different order than the realities of the world of creation, which are the object of a permanently revisable scientific knowledge, or of calculation, of

translation of the bible (1900) and a grammar book (1852), completed by Bishop Samuel Ajayi Crowther. Before this, Yorùbá had been written in ajami, an arabic script, by Yorùbá Muslims, but very little material from this time exists today. See Ajayi (1960) and Ogunbiyi (2003) for more on how Yorùbá came to be written.

> predictions that can be proven wrong; and he also knows that this possibility of revision lies in the demonstrable or verifiable character of the knowledge or the hypothesis, a character whose legitimacy he challenges in the case of his belief, but which, inversely challenges the legitimacy of his belief. Thus he must simultaneously assume both his affirmation and the challenge to it, a challenge that belief is, nonetheless, supposed to make impossible on its own level. In other words, the contradiction is inside his faith, and that is what it is "to believe." This situation is the result of the distinction made between two worlds: the Kingdom of God and this world" (Pouillon 2016, 489–490).

For the Dangaleat, by contrast, there is no word that encompasses all of the meanings of belief because, "il s'agit…de la foi en acte" [it is a matter…of faith in action] (Pouillon 1979, 47). There is no need to proclaim the existence of something which is so obviously in existence. Instead, the Dangaleat act in relation to their deities or spirits; they worship them or trust them, but never state their existence. Their faith *is* an action.

Pouillon concludes that a universal definition of religion is impossible despite it being all too common for scholars to operate, "comme s'il était evident que tout homme 'croit'…de la même façon" [as if it were obvious that everyone "believes"…in the same way]. Similarly, Talal Asad (1993; 2012) is concerned with exposing the cultural and historical specificity underlying a conception of religion that requires the centrality of belief. For Asad, the consequence of this move, in which Clifford Geertz (1966) acts as his foil, is political as it separates religion from domains of power. The problem is that both belief and faith[55] are conceived of as inner states, divorced from material processes. By invoking the "corrective processes" supported by St.

[55] Here Asad challenges Wilfred Cantrell Smith's use of faith in *The Meaning and End of Religion* (1962).

Augustine, Asad argues "it was not the mind that moved spontaneously to religious truth, but power that created the conditions for experiencing that truth" (1993, 35). To account for power, Asad would rather we consider the "relationship created through, maintained by, and expressed in practice" (2012, 208).[56] Again, action is foregrounded in the study of religion.

While both Pouillon and Asad refute the possibility of a meaningful universal definition of religion, Pouillon is alone in putting forth a surprisingly closed conceptions of modern Christianity. Returning to the context of Christianity in Nigeria, Pouillon's discussion of the modern Christian conception of the world feels less relevant than that of the Dangaleat. Here, Christianity (or Pentecostalism more specifically) takes on a quality that shares more in common with Yorùbá traditions as they are practiced in Nigeria. The aspect of belief that expresses affirmation of existence is irrelevant. Take, for example, Seyi. Whether or not she believes in the existence of God is never called into question. Her failure according to Mama David is that she did not *act* (by praying and fasting), and by extension did not have faith. There is a mutual relationship (a relationship of exchange for Pouillon or a legal contract for Asad[57]) that is implied in this conception of faith. The action serves to fulfill the believer's part of the agreement. Having faith *is* action.

If we consider the Yorùbá taboos of speech in relation to pregnant women it may seem that belief as an inner conviction takes precedence. To open the chapter, I described how women do not ever give voice to the risks that they know can prevent the desired delivery outcome.

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[56] In the subsequent parenthetical Asad defines practice as "activity that depends on the developed capacities, the cultivated sensorium, of the living body and that, in its engagement with material objects and social conditions, makes meaningful experience possible" (Asad 2012, 208–209).

[57] Interestingly, both Pouillon and Asad also point to ways in which notions of belief/faith have historical resonances in "secular" contexts. In "Thinking about Religious Belief and Politics" (2012), Asad notes that *infideles*, which normally is glossed as nonbeliever, was historically used in legal contexts to refer to someone who had broken a contract or oath. Poullion (1979) mentions that in *Le vocabulaire des institutions Indo-Europeenes* (1969), *croyance* [belief] is discussed in a section on "obligations économiques" [economic obligations].

Before a successful delivery, while a woman is still pregnant, she is greeted with, "*A gbọhun ìyá, a gbọhun ọmọ*" or "*A sọkalẹ anfani*." While both are understood as prayers and the expected response is *Amin*, literally translated they are less requests than they are statements of fact. In the first statement, "*We hear the mother's voice, we hear the child's cry*," a well-wisher evokes the scene after a successful delivery. Both mother and child are alive; their voices are heard. In the second, "*We*[58] *descend favorably*," the baby's descent through the birth canal happens smoothly without fatal consequences.

For Ogunade (2009), this taboo evokes an important aspect in Yorùbá religious traditions. Faith, itself, has a certain effectiveness and doubt can work contrary to it. Rather than imply that the inner mental state is the distinguishing characteristic of Yorùbá religion, this conception of faith erases the distinction between inner and outer, belief and practice. Here, Pouillon's nuance is useful. The existence of God, the Holy Spirit, and other evil spirits is undeniable for the pregnant women at MCH and at the mission home. They do not believe in (croire à) spiritual agents in the sense of affirming their existence, but they do have faith/confidence/trust in (croire en) them. Again, a relationship is implied. Even without a corresponding bodily action, faith induces transformations in the world.

Interestingly, *gbàgbọ́* and *igbàgbọ́* are not terms used in relation to Yorùbá religious traditions (or Islam[59] for that matter). Instead, *bọ òrìṣà* [to sacrifice to a deity], glossed as "to worship," might be the closest to "faith." Recall that there is no distinct Yorùbá concept that corresponds to modern definitions of religion.[60] It follows that if the Yorùbá practices that are

[58] One could surely say more on the use of the first-person plural here, but all too much has already been said on the importance of "community" in African "culture" so I will refrain from adding my own comment.
[59] The word for Islam in Yorùbá is *imale* as it is thought that Muslim traders from Mali played a significant role in the introduction of Islam to the region.
[60] *Ẹ̀sin* can be used to refer generally to "religion," but is better translated into worship as *sin* means "to serve" and is also used in the context of taking care of domestic animals or for a slave in relation to their master. See Peel

now considered to be religious were not ontologically separated from other aspects of life, similar practices and associated dispositions might also find their way into the Yorùbá practice of Christianity. The worldview that revolves around the distinction between public and private, the material world and the spiritual world does not fit here. For the pregnant women I encountered, it is not a matter of an inner self reflecting outer practice. Their belief is never in question and their faith is a practice. In all of the various ways described, by praying, fasting, singing, and even by simply saying the words, they practice their faith. And this practice has an effect on outcomes in the world, their health, their pregnancies and deliveries.

To be clear, it is not just that faith in the form of practice has efficacy in the way that anthropologists have analyzed ritual. What I argue is that not only is the distinction between belief and practice irrelevant, but faith (which I am using to signify the erasure of this dichotomy because of the ways it must be spoken and enacted) is a requirement for a successful exchange with God.

This detour into conceptions of belief, faith, and religion has significance not only for understanding the choices Nigerian women make in relation to their pregnancies, but also for the clashes between church and state over where women should be allowed to deliver (discussed in the next chapter). Here, the question becomes if, as Ogunade argues, "faith [is] the dominant factor with which [Yorùbá] achieve their desired results" (2009, 3), why do women collect radically opposed forms of care over the course of their pregnancies? Or put differently, does collecting care contradict having faith? Before returning to this question, it will be useful to address the problem of medical authority amidst considerable uncertainty.

(2003), specifically Chapter 4, "Making Country Fashion" for a more thorough discussion of Yorùbá religious practice as a part of daily life.

Faith and medical authority

If, as I am suggesting, faith is a set of practices that pregnant women perform in order to ensure successful deliveries, how do certain practices (and not others) come to be recognized as appropriate ways of demonstrating faith? Answering this question requires paying attention to forms of authority, disciplinary processes, and historical shifts in how they are recognized. As Asad asks, "How does power create religion?"[61] A much broader albeit interesting question, I limit the scope here to authorizing discourses and legitimizing practices in the context of pregnancy care in Nigeria. Differing configurations of power have both shaped the landscape of maternal care available to women and the calculations women make in relation to their care. Amidst seemingly endless options[62] for pregnancy care, providers attempt to establish their authority in different ways. However, among competing epistemologies, the mission home uniquely encourages women to find authority within.

As described above, informal medical systems thrive in Nigeria. The enormous variety of birth attendants found in care provider markets make the problem of authenticity particularly tricky both for women seeking care and care providers seeking to establish their authority. The contours of local health care delivery in Nigeria have been shaped by a series of national and transnational reconfigurations of power set in motion even before Nigeria's independence, which was itself an extended process, arguably more performative than legitimate. With respect to

[61] From Asad (1993, 45). I want to point out that I do not think that paying attention to power in religious practice – following Asad's idea that religious power creates conditions for experiencing religious truth – precludes the possibility of taking religion seriously. It may seem that by revealing historical shifts in practice one also reveals religion's fallacy or perhaps, inconsistency. This could not be further from the case and, anyway, is not the objective of my work.

[62] The concept of patients simultaneously interacting with multiple competing medical systems is not new to medical anthropology, receiving a considerable amount of attention in the 1970s and 1980s under the term, "medical pluralism." See, for example, Janzen's (1978) work in the former Zaire. For a general review of the concept and its critiques, see Hsu (2008). Like many of its critics, I do not find the concept of "medical pluralism" useful because of its lack of attention to power among other reasons.

health, in the immediate postcolonial period and especially following the oil boom in 1970, Nigeria embarked on an aggressive public expenditure program. As the government expanded, so too did public health facilities. Health care, largely centralized in public hospitals and clinics, was free for many and highly subsidized for everyone else. This period did not last long. In response to a collapse in oil prices in 1985 and rising indebtedness, the IMF encouraged Nigeria to implement structural adjustment programs. Subsidies were removed. Public utilities were privatized. The currency was devalued. And the public health care system was all but completely neglected. Financial mismanagement in the government and a series of military coups only compounded the deterioration. The result was that while state delivery of maternal health services declined, a largely unregulated private sphere flourished. Private practitioners, healers from within the Yorùbá tradition and mission homes were less affected and continued to offer their services. It would seem that a nation whose power was constantly undermined by neocolonial forces was having difficulty establishing and sustaining its own legitimacy. Without strict state regulation, especially in the rural periphery, what other authorizing systems are maintained?

The decline in public health expenditure of the 1980s has had lasting effects despite more recent (internationally-financed) expansion of government-sponsored health programming. The presumed authority of government had been compromised in the local setting. Even in Ondo, where the governor was actively investing in maternal health, women, especially in the state's rural southern region, expressed fears that they would arrive at government health facilities in labor only to find that there was no staff, no electricity, or no supplies. Unpredictability had led to a decline in trust and the perception that even when available, staff either lacked expertise or did not care enough to give proper care.

Still, providers in Ondo state hospitals tended to use their proximity to the state to establish authority. In Akure and other semi-urban areas, pregnant women attend antenatal programs in large numbers. At MCH, ọkọ olóyún led the antenatal program and the praise and worship segment of the program. He is seen as a representative of the state. The hospital is after all nicknamed, "the governor's hospital" as a result of a successful branding campaign by Governor Olusegun Mimiko. This included publicized visits to the hospital, various programmatic "launches," award ceremonies, parades, and even the choice of a new orange and white color scheme[63] for the state. These efforts, a calculated set of techniques, had the effect of on the one hand, distancing Ondo from Nigeria's national failures, and on the other, tying the governor closely to the hospital. By advancing Ondo exceptionalism, Mimiko attempted to regain trust in the public in recognizable ways. Even when the governor was not present in person at a given hospital or clinic, his presence was felt in the orange paint which had been applied to cover the National colors, green and white, from before his incumbency.

Though MCH in Akure served as the centerpiece of the state's linked media and health campaigns, providers were well aware of competing sources of care, which they actively worked to delegitimize. Women were made to watch movies and listen to health talks that chronicled the ill-fate of women who chose to deliver or receive care outside of the hospital. These women are portrayed as uneducated and their practices are meant to be interpreted as ridiculous. Ọkọ olóyún is particularly engaging in his story-telling. Rather than simply list the things pregnant women should or should not do, he tells elaborate stories, in which an uneducated pregnant women or birth attendant makes fatal mistakes. The pregnant women in attendance laugh heartily as ọkọ

[63] During Governor Olusegun Mimiko's two terms, the official state color was changed to orange. All state buildings, hospitals included, were painted bright orange and all printed material were branded with the new state color and logo.

olóyún acts out the part of a birth attendant who, after reluctantly taking her client to the hospital for a Caesarian section, exclaims with wide eyes, "Oga I no fit o, but I thank God o." Upon seeing that the baby was 5.3 kg, she admits that she would not have been able to deliver it on her own and thanks God for the hospital. That she is uneducated is made evident by her use of pidgin English among other more embodied qualities pantomimed by ọkọ olóyún. Health talks take a slightly different tone away from the capital as providers in these areas must be careful not to insult the women present.

Elsewhere informal providers must find ways of legitimatizing their practices without the official support of the government. Sarah Pinto (2004) explores this problem in her work on what she calls "ersatz medicine" in rural North India. She considers the "self-made medical authority" of those "who work on the margins of legitimacy," (2004, 337) and argues that they establish legitimacy through mimesis of certain development and biomedical practices, even at times securing quasi-institutional roles at NGOs. These are practitioners that have not undergone formal training but through personal savvy have been able intercalate themselves into development institutions, learning how to communicate, deliver babies, and even give injections in ways that make it seem as if they are legitimately part of the biomedical development world when in actuality, they remain at best on the periphery.

For Pinto's "quacks", the authorizing power of institutions comes, at least partially, from "bahar" or outside (2004, 342). The biomedical-development complex gains power from being seen as foreign. By contrast in Ondo, while the state government was interested in aligning itself publicly with international agencies and personalities (WHO, Ford Foundation, Bill Gates, and even Harvard Medical School via my own presence), this is less the case for private providers whose ways of knowing are vastly different from that of the state.

Instead, mission home providers draw authority from the word of God. “Prayer is our Panadol!” Mama David shouts frequently, “There is nothing God cannot do!” She refers to bible passages to illustrate her messages. An often-referenced one is Exodus 1. In it, midwives are ordered by the king of Egypt to kill all male babies but allow the female babies to live. The midwives, fearing God, do not obey the king’s order and are rewarded with families of their own. The passage is not simply meant to be self-serving. The pregnant women are meant to be comforted by the knowledge that their own midwives also fear God. Even if others (namely the government) try to get in their way they will complete the task at home and be triumphant.

Like MCH providers, mission home attendants also attempt to divert women from seeking care elsewhere. They tell stories of women being operated on against their will, resulting in not only the death of the mother or baby but also a hospital bill that is impossible to repay. Hospitals and the doctors that practiced in them were conveyed as cold, cruel, motivated by economic incentives, and impatient, too quick to resort to excessive intervention. These traits lead to the mistreatment of the women who naively trusted them. At the same time, as I noted earlier, Mama David selectively invoked biomedicine in order to present the mission home as effective and legitimate. She mentioned that Funmi chose to deliver in the mission home even though her husband was a doctor. She also once told me that despite the government shutting down other local mission homes, theirs had been one of the only ones allowed to stay open because of how respected Mama Àbíyè was. Along these lines, I often found the ritual objects of a biomedical clinic, however outdated, in mission homes even if I never saw them actually being used. This seemed to be intended to give women the sense that the space was for legitimate healing practices. I should point out that hospitals also adopt techniques from churches; the prayers and songs are all borrowed from churches.

Apart from the deliberate efforts to convey authority on the part of providers, women's experiences and dispositions towards the care they received were influenced by the structures of authority in different spaces. At MCH, ọkọ olóyún leads the antenatal program. He almost commands the woman to stand up and dance with him. An image of soldiers in an army is evoked. He is joined by a staff of nurses, midwives, and aides, who sometimes do some of the teaching, but his role is central. However, the point I want to make here is not about the gendering of care. At other government hospitals and health centers and on other days, a woman might lead these sessions. If anything, women seem to dominate the provision of pregnancy care across most setting. I want, instead, to emphasize the difference in how Mama David and Mama Àbíyè (with the occasional help of the pastor) lead in the mission home.

The key difference in authority structures are the ways in which woman are allowed to participate. At the mission home, especially smaller ones, the women play an active role in their own salvation. They lead songs, give testimony, and tell each other stories of previous pregnancy experiences. The structure of prayer meetings allows space for this in ways that the hospital does not. In an unexpected way, women are also encouraged to trust themselves. Mama David frequently mentions the importance of listening to the Holy Spirit for guidance.

Paying attention to the Holy Spirit manifests throughout the lives of the pregnant women. Mama David gives the mundane example of the Holy Spirit's guidance in choosing which taxi to take. A common refrain in regular conversation is, "my spirit told me to…" followed by any imaginable decision or activity. My spirit told me to call you today. My spirit just told me that something did not seem okay so I stayed home. The Holy Spirit is personalized, offering specific guidance to each person. In this way authority is dispersed. Each woman interprets the guidance she receives – how she should display her faith, how she might get her desired pregnancy

outcome – in her own way. Yes, there are ways that this sort of listening is cultivated. The women do after all attend hours and hours of prayer meetings weekly and are influenced by the pastor's teachings, bible studies, and their lived experiences within the church. This is why a three-day night vigil is often proposed as opposed other less acetic practices. Even so, against what one might expect at a church, women are inadvertently instructed to look within for answers, to trust themselves.

Missing from this discussion are the ways that the government attempts to curtail the practices of unlicensed providers. This is largely because though laws and licensing bodies exist, this did not seem to bear any impact on the sheer quantity of unlicensed providers or the quality of care they provided. At the same time, I did not get the impression that the state was desperately falling short in its effort to maintain control over medical authority. It seemed to on one level sanction it, if only by turning a blind eye. Ondo was an exception, which I discuss further in the next chapter.

In focusing on the various extra-legal tactics of establishing authority, I have shown how the various forms of authority and legitimizing practices bear on the experiences of women seeking pregnancy care. Because it is important for women to demonstrate faith in order to have successful pregnancies, care providers must demonstrate that women can place their confidence in them. While multiple tactics are employed to this end, none would be successful without reference to God. Note how God is not incompatible with what is presented as the modern space of the hospital. When ọkọ olóyún mocks women who go to mission homes it is not because they naively have faith in God, it is because they naively have faith in unskilled birth attendants. He would have the women listen to him, put their faith in God at the hospital. The rhetoric in

Pentecostal mission homes is entirely different. By encouraging women to let the Holy Spirit guide, women are empowered to know their own truth.

When I asked Tolu (who as you may recall registered her pregnancy at both MCH and the nearby mission home) where she wanted to deliver, she said, "God will guide me." She explained that her husband wanted her deliver at the mission home, but she was net yet sure. She was waiting for God to show her the way and expressed confidence that the truth of her own place of her delivery would be revealed to her in time. In the meantime, she was hedging her bets, collecting all the care at her disposal that might come in handy at the critical moment of her labor and delivery.

Care as Faith, Faith as Care

The interwoven tales of Tolu, Seyi, and Funmi, brief examples of encounters with the complex landscape of maternal care providers in Nigeria, offer a less commonly told picture of how women seek and receive care during their pregnancies and deliveries. While one cannot deny the overwhelming sense of optimism based on their faith that women projected concerning their impending deliveries, these women also simultaneously went about collecting care. They registered their pregnancies with multiple providers that seemed to espouse competing ways of knowing and healing. Moreover, they accepted, ingested, consumed, in a word, "collected" the care given at these different sites: iron tablets at the hospital, holy water at the mission home, an herbal concoction made by a Yorùbá herbalist. Yet, the paradox evident between having faith in God's power to ensure safe deliveries and seeking multiple forms of care was not felt as a tension for women.

Jacob Ayo Adetunji (1996), in his study of pregnancy care processes in Efon Alaye (notably the location of one of the country's only two CAC mission home training centers),

described the "principle of maximizing protection." He found that pregnant women "crisscrossed between faith clinic, maternity centers and modern hospital" in order to "get both natural and supernatural protections from real and imagined foes" (Adetunji 1996, 1565). The Yorùbá proverb, *ọ`nà kan kò wọjà* [there is more than one way to enter the market], is used to further elaborate the principle. I find that this proverb is not only helpful for illustrating this principle, but also has deep significance for understanding Yorùbá cosmologies, which tended to be more incorporating than exclusionary. The practices that women engage in as they "crisscross" to different providers are not only instances of care, but demonstrations of faith, expressions of confidence, fulfillments of their side of a relationship in order to ensure reciprocation.

In the first chapter, I attended to the inextricable histories of Christianity and biomedicine in colonial Nigeria and also interrogate the ways in which church and state in Nigeria have been discursively unlinked in the age of global health. Here, I continue to explore the ways that the specific forms of worship in Pentecostalism have been uniquely adopted and transformed in Yorùbá communities, perhaps as a result of resonant orientations toward an at once spiritual and material world. One would be hard pressed to find a delivery setting that had not been endowed with the spiritual. All care is spiritually invested. Pentecostal efforts to attend to pregnant mothers cannot be ignored as relics of a religious past or impediments to a modern future. Attempting to demarcate the religious from other spheres of life would not only be a difficult task but also might run contrary to Yorùbá ways of being in the world.

This messiness of shifting authorities and competing practices of legitimization is also productive of caring moments, demonstrations of faith, and successful deliveries. However, amidst international attention on the problem of maternal mortality, it has become easier to see the disorder as productive of the problem. Ondo state's vision of progress very much depended

on indicators of development as defined by organization like the United Nations and World Health Organization. In his addresses, Governor Mimiko often referred to millennium development goals when he laid out his plans for Ondo's success. Not surprisingly, women's reproductive lives, were central to the vision. In the next chapter, I discuss Ondo's attempts establish centralized, singular medical authority but only in respect to women's reproduction by enacting political secularism. The women's body is imagined as a public space, from which religion must be eliminated in the process of this modern project.

Chapter Five
Secular Motherhood: Contested sites for postcolonial aspirations

In an online blog article, Leo Igwe, a Nigerian human rights advocate and self-proclaimed atheist, asks, "Can Atheism Reduce Maternal Mortality in Nigeria?" raising the question of a correlation between religiosity and health. Igwe sums up his answer to the question he proposes in a tweet with a link to the article, "#Atheism can reduce and eventually root out maternal mortality in Nigeria." In his article, Igwe argues that campaigns to reduce maternal mortality are failing because they do not address one central issue: religious belief. He advocates for public health campaigns to emphasize the message that, "There is no God and no benefit to fasting and praying." His ideas evoke assumptions about secularization that have come under scrutiny in the past few decades among scholars of secular studies, namely that the decline of the social significance of religious belief is essential to unlocking the full benefits of modernity. While the secular was previously imagined as a decline in the public importance of religion and a liberation from its ideological limitations in order to gain direct access to reality, it is increasingly understood as having specific European and Christian historical roots (Asad 2003; Taylor 2007). This understanding of the secular, as historically constituted, has important implications for the place of religion in the modern project.

Following Talal Asad (2003), I do not subscribe to a dichotomous view of the religious and the secular. I treat the secular as a set of concepts, practices, attitudes, assumptions, and sensibilities that are not devoid of religion, but have come together over time in ways that support secularism. The political doctrine of secularism then is a normative project of government that entails the intervention into religious traditions under the guise of separation of church and state, neutrality, tolerance, and freedom. As Saba Mahmood notes, it is "the

sovereign prerogative of the state [and, I add, other non-state institutions] to regulate religious life through a variety of disciplinary practices that are political as well as ethical" (2015, 293). In this way, the domains of the secular and the religious are co-constitutive rather than devoid of each other. Yet the project necessitates the specific construction and distinction of categories of the secular and religious that "nonmodern" people must strive toward. What counts as "secular" and "modern" and what is labeled "nonsecular" and "premodern," is determined by discursive operations of power emanating from the North-Atlantic but taking on varied forms across geographic contexts. The place of religion in each modern secular nation-state varies and thus the "mediating character of the modern imaginary in each of them differs significantly" as well (Asad 2003, 5–6). We might ask, what form does secularism take in Nigeria?

In Nigeria, where atheists like Leo Igwe are in the extreme minority[64], the state has had to grapple with questions of religious pluralism since its creation in 1960. For Simeon Ilesanmi, religion is Nigeria's single biggest problem. His work, *Religious Pluralism and the Nigerian State*, explores religious pluralism as a modern predicament. In precolonial times, he argues, "the sacred and the secular were not artificially bifurcated" (Ilesanmi 1997:xx). Colonialism not only brought Christianity via missionaries into competition with Islam, which had arrived centuries earlier, it accentuated the provincialized religious practices that were already present in Nigeria. Mahmood (2015) describes a similar process in her work on minority religions, namely Coptic Christianity, in Egypt. She traces current debates over the secular concepts of religious liberty and minority rights to their introduction into Middle East between the nineteenth and twentieth centuries and argues that rather than reducing religious difference, secular governance has the effect of intensifying it. Early efforts made by Christian Europe to extend these concepts to the

[64] Less than 1% of Nigerians identity as atheist or agnostic according to Pew studies.

Ottoman Empire were thwarted, but as Ottoman rule declined, concepts of religious liberty and minority rights were adopted more readily in the attempt to shift loyalties to the emerging nation-state. Colonial powers subjected pre-existing religious differences to a new grid of intelligibility, transforming religious subjectivities in the region. The rise of both Islamist movements and the Coptic presence in civil society is not a sign of the failure of secularism, but rather a result of the nation-state's secular operations. Modern secular governance has not fulfilled its promise of reducing religious tensions and hierarchies; rather it has transformed religious forms, further polarizing religious difference.

In this regard the paradox that Nigeria finds itself in, a legacy of the colonial forces that generated and effectively embedded the category of religion in social and political life, is quintessentially secular. On the one hand, following independence, elite nationalist politicians, educated in Europe, belittled religious particularities as expressions of an unenlightened past, a "mystic irrationality" (Ilesanmi 1997, 14). Politics needed to be liberated from the burden of religion for Nigeria to progress. On the other hand, the same elites must contend with the omnipresence of religion in Nigeria, even at times employing religious difference as a form of social and political mobilization. In this chapter, I demonstrate how this paradox plays out not only in the political institutions of government but through its medical techniques of governance.

I argue that while the Nigerian state adopts secular logics in attempting to make clear the distinction between religious and non-religious modes of care, the lived experience of Nigerian women defies these logics. Meanwhile, international funding is tied not only to Ondo's performance on specific reproductive health indicators, but to the global perception of its "readiness" to be modern. The state, thus, condemns birth practices that resist its secular mission while authorizing other modes of religious subjectivity, as demonstrating "secular motherhood"

becomes more important than ensuring "safe motherhood." While many scholars of development and critical global health have pointed out the potential for global health to be neocolonialist, I build on these critical engagements with global health by bringing these debates into conversation with recent scholarly work on secularity (Asad 2003, Taylor 2007, Mahmood 2015, Whitmarsh and Roberts 2016). What role does political secularity play in the modern project of development and how does secularity constrict the possibilities for development progress?

The problem of where women deliver

A common refrain among the women who work in *Ile Abiye's* mission home is, "Prayer is the best medicine," and they mean this quite literally. The mission home birth attendants pray with and for the pregnant woman. They offer them sanctified water to drink. By apprenticeship, they have learned the symptoms to expect in pregnancy and the signs that indicate labor, but they do not order lab tests or prescribe medications. They coach pregnant women in how to push during contractions, deliver the babies, and remove the placentas. But they do not use continuous fetal heart rate monitors, set IVs, or perform Caesarian sections. In fact, women who attend the mission home are discouraged from seeking out these biomedical technologies and instead told to put their faith entirely in the power of God.

Amidst the resonances between the hospital and the church, it is this distinction that matters most to global health experts. Where a woman delivers and who is present at the delivery are seen as such a significant predictor for maternal survival that the main proxy for the goal of decreasing maternal mortality rates is the number of women who deliver in hospitals and number of births attended by "skilled" providers. Skilled, according to the WHO refers to job title rather than an assessment of expertise. To be skilled, one must be a doctor, nurse, or midwife, titles bestowed by the state and medical regulatory bodies. Everyone else who provides care regardless

of their experience is counted as unskilled. Clare Wendland (2016) discusses how the attention given to "skilled attendance at birth" has sometimes had perverse effects on health systems. As some areas emphasize the need for more skilled providers, the tools and infrastructure that these providers need to effectively employ and maintain their skills are given lower priority. She notes that interestingly this indicator has never even been conclusively demonstrated to matter to maternal mortality. It is an assumption that is commonly accepted, but has never been verified (Wendland, 2016, 68–69). As I show below, Ondo is conscripted into designing its public health programs around this unsubstantiated rationality because it has become a condition for continued aid.

As I discuss in Chapter Three, reproductive health indicator like these also serve as a marker of development. Stagnancy in maternal health statistics then indicates more than just loss of life. In Nigeria, the maternal mortality ratio (MMR) may have even increased between 2008 and 2013 from 545 to 576 although experts contend that the difference is not "statistically significant" (NDHS 2014). Because making sure women are in the right place at the right time requires a particular arrangement of infrastructure, people, money, and things, high maternal mortality rates are often read as indications of gender inequality, political instability, corruption, poverty, and low levels of educations. It conveys a failure on the part of the government in its ability to usher Nigerians successfully into the modern world—a world they are, of course, already apart of. Many scholars have shown how women by way of reproduction have served as sign posts for development. I build on their work by arguing that the performance of secularity is central to this project.

Ondo performs worse in these reproductive health indicators than any other state in its relatively wealthy and conflict-free region, of which Lagos is a part. Ondo has linked this failure

to increase the numbers of women who deliver in hospitals to a protracted process of secularization. As such, Ondo has been the most active in combating what it sees as an epidemic of out-of-hospital births. They frame mission homes as being responsible for a majority of maternal deaths and see the overly religious as being detrimental to state progress. This has resulted in local battles over the right to care for pregnant women with community and religious organizations insisting on continuing to play a role despite government mandates discouraging them.

Crafting the "right" setting

In Ondo State, as in many areas determined to lower maternal mortality rates, health officials strive to make sure above all else women deliver in the "right" setting. The previous governor, Olusegun Mimiko, a physician and the former state commissioner for health, began making good on his campaign promises to improve Ondo's health system almost as soon as he took office in early 2009. Prior to his election, Nigeria's health system had suffered from a series of setbacks. Briefly, in the immediate postcolonial period and especially following the oil boom in 1970, Nigeria embarked on an aggressive public expenditure program. As the government expanded, so too did public health facilities. Treatment at all public hospitals was free for many and highly subsidized for everyone else. In 1986 in response to a collapse in oil prices and rising indebtedness, the IMF encouraged Nigeria to implement structural adjustment programs. Subsidies were removed. Public utilities were privatized. The currency was devalued. And the public health care system was neglected. Financial mismanagement in the government and a series of military coups only compounded the crisis.

According to NDHS 2009, Ondo had felt the effects of a decimated public health system more than any other state in Nigeria's predominantly Christian and Yorùbá southwest region. In

the category of maternal health, the study found that Ondo had the lowest rates of hospitals births and the lowest rates of births attended by skilled health providers. In response to what was deemed a complete embarrassment, the Nigerian government introduced a health program with three stated goals in mind: to reduce child mortality by 50%, to reduce maternal mortality by 50%, and to increase facility utilization by 60% over the course of the next two years. The former governor's plan was called *Abiye* (not to be confused with the mission home with a similar name—*Ile Abiye*). *Abiye*, here, is translated into "Safe Motherhood," whereas I*le Abiye* might be more commonly understood as "House of Livebirths." The *Abiye* program entailed a complete overhaul of the state's health system, which involved building new hospitals including the state-of-the-art Mother and Child Hospital (MCH) in the state capital, renovating old ones, and recruiting doctors and nurses. Most importantly all care, from immunizations to Cesarean sections, was to be free.

This initial strategy was one of "If you build it, they will come." The flawed assumption being that women were not going to hospitals because of their deplorable conditions. If there were suitable places for women to deliver at no cost, they would abandon alternative medical systems for the easily accessible modern substitute. Yet, informal medical systems continue to thrive and woman continue to seek reproductive health care from birth attendants in private settings. In Nigeria 50% of women receive the minimum recommended level of antenatal care, but only 35% deliver in health facilities and 38% of births are attended by "skilled" health providers (NHDS 2013). These numbers, first of all, confirm that a large portion of perinatal care is received outside of approved health settings. Most women in Nigeria are not delivering in hospitals. Secondly, the numbers tell us that more women attend antenatal clinics than those that

ultimately deliver in health facilities. This suggests that access is not the problem for at least this subset of women.

Even so, rather than addressing the possibility of deterrents beyond access, the state forged on in its efforts. An initial study found the *Abiye* program had led to what seemed like a drastic reduction in the maternal mortality rate in the state, but the government was rightfully concerned that they were not capturing all of the maternal deaths. As a result, CEMDOS, the Confidential Enquiry into Maternal Deaths in Ondo State, which mandates the reporting and investigation of every maternal death, was passed into law in 2010. Both the World Bank and WHO have released reports which recommend the use of audit as a method of both collecting information and improving maternal care services. Ondo's CEMDOS stated that if a woman died anywhere, within 48 hours a relative must report the death irrespective of the setting in which the death occurred. Failure to report resulted in jail time and/or fines. However, there were no punitive measures for reporting. At an Ondo House Assembly meeting, the medical director of one of the *Abiye* hospitals presented emphasizing this key point. He announced, "The law goes a long way in protecting the confidentiality of the informant," and added later, "No name, no shame, no blame."

By enlisting Ondo residents, specifically relatives of the recently deceased, in state maternal mortality surveillance, the state shapes their attitudes toward the deaths. Every maternal death is a lesson learned. Family members of the diseased are compelled to link the death of their mothers, wives, sisters, daughters to the circumstances that they report to the government. The specific set of questions asked render the death legible in a particular way. Where did the death occur? Who was with the woman at the time of death? What was the training of the birth attendant?

Forensics—both the inquiry and subsequent judgment—is used to determine social standing here. In *Forensics of Capital*, Michael Ralph considers the use of forensics beyond the realm of policing and criminality. One's forensic profile—often based on subjective assessments rather than objective criteria—shapes access to resources and is indispensable to participation in a given polity (Ralph 2015). In adjudicating whether a maternal death was avoidable or not, tolerable or not, Ondo passes a judgement about the birth attendant. Even though the evidence examined might be interpreted in different ways (for instance, recall that unskilled attendance at birth has not been proven to increase the risk of death), the birth attendant, having already been labeled unskilled, is always unfavorable judged. The exercise is only played out to make this clear to all other parties involved. Every maternal death under CEMDOS is oriented toward the future that Ondo is looking to create.

While the law was originally written in a way that held all Ondo residents accountable yet also granted them immunity, data gathered from CEMDOS was used to justify the next set of maternal health regulations. The brief period of impunity that CEMDOS allowed for was supplanted by programming that actively sought to assign blame when the expectation that mission homes would become irrelevant as women were exposed to the benefits and efficiencies of biomedical care did not prove true. In 2013, the government revealed *Agbebiye*, a program meant to complement *Abiye*. *Agbebiye*, which means birth attendant in Yorùbá, is a set of interventions aimed at birth attendants deemed "unskilled." All community birth attendants were prohibited from delivering babies, an offense that could be punishable by jail time and fines if an attendant was found to be responsible for a maternal death. To ease the transition, incentives were created to provide birth attendants with alternate sources of income. Community birth attendants were to be paid 5000 Naira (about USD $15) for each referred client that delivered in

a government health center. Additionally, the state held training programs to teach birth attendants new skills and micro loans of up to 100,000 Naira (USD $300) were made available for birth attendants to start new enterprises. Realizing that women were willingly choosing to give birth in churches despite improved access to hospitals, *Agbebiye* was expressly designed to deter a woman from delivering a baby in "the wrong setting."

Making Ondo Modern

Ondo state's intervention into the religious practices of women can be linked to its relationship with foreign powers. State officials must present Ondo as a worthy recipient for external funding and support. Ondo must be "modernizable," which, in part, implies that Ondo must already be "modern." In other words, modernity is not an end result, but a project which depends both on an ideal imaginary and its other, separated by both time and space.

Attempts to modernize Africa have historically comprised both the religious and the economic. William Pietz (2000) described the 1887 British capture of Benin City as being supported by the king's unwillingness to comply to two demands. First, the British had been urging him to end his monopoly over the flow of goods and open his country to free trade. And second, they implored him to enforce the treaty he had signed abolishing the practice of human sacrifice. When the British troops successfully took Benin City they found, in the words of British captain Alan Boisraigon, "altars covered with streams of dried blood…everywhere, on each path, were newly sacrificed corpses" (1897, 187). Exaggerated accounts of the sack of Benin City accompanied by photographs traveled back to the British public and served as an important other to the civilization of British public discourse. As Pietz writes, "civilization came to name a specific, proactive policy. Civilization (at least, in reference to Africa) meant the

replacement of human sacrifice with Christianity and the replacement of slave dealing with what was called 'legitimate commerce'" (Pietz 2000, 56).

In postcolonial Nigeria, development has replaced the project of civilization. But this latter modernization effort still requires an other, the break from which is religious as much as it is economic. Former Governor Mimiko went to great lengths to distance his *Abiye* program from community and faith-based birth attendants. In almost every public speech on the matter, he condemned the activities of mission homes, describing their practices as "backwards," "in the dark," and "ignorant." As doctors work to align themselves with state ambitions and international development agency expectations, the *Abiye* program becomes a space where the threat that Pentecostalism poses to modern liberal sensibilities must be contested. Mission homes, in paralleling the *Abiye* program by also professing to know how best to care for pregnant women, pose a particular risk for *Abiye* health care providers. Even as many doctors and nurses in *Abiye* hospitals attend Pentecostal churches themselves, they often frame the practices of mission homes as encroaches on their ability to do their jobs.

At a "Mortality and Morbidity" meeting that I attended at MCH, for instance, a young doctor presented six pediatric mortalities to an audience that consisted of the entire hospital staff. There were two patients with severe malaria, one of which was HIV positive. Another two had bronchopneumonia. One was diagnosed with neonatal sepsis before dying, and the last died from cerebral malaria. After he detailed the particularities of each case, the chief medical director, Dr. Oyelele, a man with a permanent half smile on his face, asked the young doctor what he thought the cause of death was for all six cases. The young doctor timidly spoke into the microphone, "Sir, well, you see, they all presented late."

"God bless you. That is exactly correct," Dr. Oyelele spoke a little too loudly into the

microphone, before adjusting down his volume. "The problem is we are so religious, everything that happens you call your pastor first…Instead of going to the hospital, you go to the mountaintop." He continued that the delay of seeking care was the real problem that needed to be fixed. "This country is just *too religious*," he repeated over and over again. At the end of the conference, Dr. Oyelele spoke frankly once again. He was concerned with "just how religious our people are," and how this was affecting "our health." Here, the attempts to "modernize" the mentality of the nation are evident. Participation in this modern project requires the subject to reject fanaticism, abstain religious logic in inappropriate settings. For Dr. Oyelele and his colleagues, the issue is not that Nigerians are religious at all, but that some Nigerians are *too* religious, becoming a burden that holds the country back from reaching its health, and therefore development, goals.

Ondo state has also sought to demonstrate "readiness" in concrete, measurable ways. Beginning in 2008, the World Bank provided a health investment loan which constituted much of the funding needed for the operation of the *Abiye* program. This loan was tied to a results-based financing model in which money was dispersed dependent on how Ondo primary health centers performed according to goals set by the World Bank. These metrics included increasing the number of births attended by "skilled" health care providers by a specific percentage. Development agencies like the Bill and Melinda Gates Foundation have adopted similar reward-for-progress schemes. Interestingly, there was no requirement to lower the number of maternal deaths. Instead, primary health care centers were rewarded with vital funding for meeting programmatic indicators that were assumed to reduce maternal mortality according to the particular notion of science and secularism on which the UN and the World Bank, among others, rely.

If as Ralph suggests, much like an individual's forensic profile, a country's favorable standing derives in part from a forensic calculus that links a nation's diplomatic profile to its credit profile, then Ondo's access to aid is determined by the ability to demonstrate that it has met clearly defined health performance criteria. In Ralph's terms, Ondo state's diplomatic profile—and that of Nigeria, by extension—shapes access to resources. I would add that this profile in Ondo also depends on the perception of their secularity. The present discourse around mission homes serves this purpose.

The state is invested in drawing clear lines between its actions and those of mission homes. But the distinction that the secular state makes is not the distinction that is lived. The criteria to which the state adheres to appear modern, secular, advanced and healthy does not abide by the criteria upon which Nigerian women draw when deciding where and how to deliver a baby. Further, Nigerian women do not construe state health clinics and mission homes as entirely separate and distinct. MCH and the nearby church mission home are not simply geographically close, they also share many of the same practices in relation to the women they treat including, praying and dancing among others. Women move seamlessly between the two spaces, sometimes receiving care from both in one day. They do not feel the need to pick sides. Yet, the state is invested in performing difference, in creating the mission home as the other to its modernity.

A maternal death in the "wrong" setting

As the newly appointed primary health care coordinator of *Igi*, a local government area in southern Ondo, Dr. Yinka Adekunle was the first to be notified when a maternal death occurred late on a Friday night in July of 2015. Dr. Yinka was sitting on the floor of his living room waiting for his intermittent electricity to return so he could finish watching a Nollywood film. In

the pitch-black silence, he listened as a member of his staff filled him in. It had happened in a mission home at a Christ Apostolic Church in a smaller village within *Igi*. They had identified the birth attendant, but community leaders had pleaded against her arrest. This was the second death that week in *Igi*, which is a two-hour drive from the capital along a winding single-lane highway. Residents of *Igi* had not had access to electricity (apart from private generators) since 2014 and many villages in *Igi* rely on bore holes for water. Because Dr. Yinka lives in the capital, he waited until Monday to make his own official inquiry into the maternal death.

On Monday, accompanied by his social mobilization officer, Yemi, and his alternative medicines coordinator, Sesan, he made the journey to the village in which the death occurred. Beyond the two-hour drive from Akure to *Igi* center, they traveled another hour to get to the village. They stopped first at the village's recently-renovated basic health center, where they were joined by the center's director. Inside, there were no patients. Only freshly painted rooms, arranged around a central reception area and stocked with unopened boxes of gloves, needles, and medicines.

Directly across a narrow dirt road, only meters away, was the mission home where the death had occurred. It was a small shack next door to a church. A group of village elders, notable community members, and curious onlookers had gathered in a field next to the church in anticipation of the arrival of the government team. Dr. Yinka addressed the anxious community members. He explained that his team had come on behalf of the state because of reports that a woman had died while giving birth on Friday. Because of new state laws, they needed to question the birth attendant. He asked for her to be brought forward. An elderly man nodded and made a motion for the birth attendant to come forward. She was young and had a baby secured to her back with a leopard print fleece blanket. She took the chair that had been placed for her in

front of the group of villagers and turned it 90 degrees so that she was facing neither the local government team nor the villagers, but instead stared directly at the church.

Yemi, the social mobilization officer, took notes as she interrogated the birth attendant. Her name was Mrs. Kehinde Owo and she had been stationed at Christ Apostolic Church Oke Igba after two years of training at a CAC mission home in Ede. She was asked if she had heard of the state's *Agbebiye* program and she said that she had heard about the education session concerning the program only after session had taken place, so had been unable attend. Kehinde was then asked to show the local government team the mission home. Inside was dark with unfinished aging cement walls and floors. She showed them into one small room on the right of the entrance. It was furnished with a hospital bed with black padding and a much smaller surface onto which she said she normally places the baby. In the far corner of the room were several plastic buckets. Kehinde lifted the lids to reveal the contents. One was filled with various clinical-looking instruments: scissors, suction bulbs. Another bucket was empty and yet another was filled with a white powder.

As the government team filed out of the mission home, it started to rain. They ran for cover into the church where the rest of tribunal had moved. Kehinde followed bringing with her the diseased woman's medical record card. Her name was Zainab Suleiman. Under "AGE," the word "Adult" was written. Zainab had three previous children. A line was filled out for every visit which occurred at least every other week until the delivery. The woman's weight and blood pressure were noted along with the vaginal appearance and whether or not the fetal heart rate was heard. The last visit was June 17th and according to the card everything was within normal limits at that time.

In the church, sitting in the pews, Kehinde explained that the death had happened last Wednesday. She had been getting her child ready for school when Zainab came to her and said she was in labor. At that moment, Zainab's water broke. Kehinde reported that she put her child down, and put on gloves to attend to Zainab. Soon after, the baby came, and it was a stillborn. Next, Kehinde said she removed the placenta and that there was not any blood, but Zainab appeared "restless" so she called the pastor, who came and prayed for her. When Zainab seemed to be getting worse, they called for a car to take her to the hospital but she died along the way.

After this recounting, Yemi and Sesan took turns explaining the mandates of the *Agbebiye* program. They concluded by declaring that Kehinde because of her role in the death and failure to adhere to the new program, was to be arrested and taken to the jail in the capital. After this decision was given, the mission home was "sealed off:" Four signs were plastered on the four walls of the building that read in English and Yorùbá:

SEALED
DANGER
DELIVERY IS DANGEROUS HERE
ORDERED BY:
ONDO STATE
PRIMARY HEALTH CARE
DEVELOPMENT BOARD

The pastor and two of the elders pleaded on behalf of Kehinde. They argued that Yemi and Sesan were being too hard on her. They promised to keep the building sealed, but asked that the team not arrest Kehinde today. She had a baby, they pleaded. She needed to breastfeed. She had not known the law. After a short deliberation outside of the church, the local government team returned to inform the community that their decision was final. They explained that they had to follow protocol—they had no choice.

After her arrest, Kehinde was transported to the capital. She sat in a jail cell overnight with her baby and two villagers who had accompanied her. She was later freed with a stern warning after paying a large, and rather arbitrary, fine. A few months later, Dr. Yinka would get a phone call informing him of another death in the same village. After being released from jail, Kehinde had tried to return to her family in Lagos, but the community leaders had begged her to stay. This second death had also occurred in her mission home under her care. But on this occasion, there would be no inquiry.

We learn from this case that networks of care do not simply arise to fill spaces of scarcity and uncertainty or in cases of socioeconomic vulnerability, as is the case in the works of medical anthropologists Julie Livingston (2012) and Angela Garcia (2010), respectively. Rather, my research demonstrates how community religious practices of care in Ondo have condensed around increasingly elaborate state health programming. For Livingston, care, both sentimental and technical, is improvised in response to the intense collective physical and existential vulnerability brought on by the cancer epidemic in Botswana. In this context of drugs, diagnostic tools, and other vital procedures in short supply, nurses and family members must learn to make do. An ethic of care emerges in the intimate moments when nurses debride necrotic wounds, change diapers, and bathe patients. Their work is interpreted as moral, providing social healing where no medical cure is possible (Livingston 2012). Even a non-believer could understand these nurses' appeals to Jesus to heal their patients as biomedicine has no answer to such late stages of cancer.

In the basic health center in *Igi*, however, the boxes of medical supplies remain unopened while women visit the mission home across the street for pregnancy care—despite the pervasive fact of arrest and incarceration. Here, it is more difficult for a non-believer to make sense of

prayer as the only form of care. However, associations between care and faith have historical origins which I discuss in Chapter Two. Pentecostalism in Nigeria is rooted in a history of faith healing in opposition to the medicines that colonial missions relied on. African Independent Churches separated from Protestant missions in order to practice Christianity in a way that they felt was both truer to the bible and to their indigenous culture. Jean and John Comaroff have written extensively on resistance throughout the process of missionization (1997). For Jean Comaroff, African Zionist Churches are at least in part a reaction to a loss of autonomy brought on by the colonial introduction of industrial capitalism. Their songs, dance, summoning of the Spirit are interpreted as political resistance and healing serves a metaphor for "the reintegration of matter and spirit, the practical agency of divine force, and the social relocation of the displaced" (Comaroff 1986, 176).

I take Pentecostalism and the desires inherent seriously without immediately resorting to neo-functionalist explanations that pose religious revival as a response to material crisis. Poverty, social exclusion, and failures to modernize or develop do not provide adequate explanation for why people prefer mission home deliveries. Rather than a movement to fill an absence, in Ondo, religious networks of care form in opposition to state mandates about when and how women must deliver babies. In this context, it makes more sense to see the investment in mission home deliveries as a demonstration of faith as well as, in some ways, a brazen act of defiance.

The former claim was made apparent in my interactions with women who attend mission homes. Miracle, a woman from Igi, had recently delivered at a mission home when I asked her what she thought was most important in ensuring a successful delivery: "Well, faith and..." She hesitated for a moment and then started again, "It's faith. Everything is faith. If you have faith, everything is faith." Miracle also described the process of giving birth at the church as being

"comfortable." She said that the birth attendant bathed her, made tea for her, and told her what to expect when she returned home. She also felt "comfortable" in knowing that the birth attendant was praying for her, that her pastor was nearby, and that she was in the house of the Lord. Receiving her care at the mission home was a manifestation of her faith in God and God had responded by blessing her with a healthy baby boy.

Making Motherhood Secular

The experiences of women like Miracle are perhaps some of the reasons why the village and church at its center insisted on having deliveries take place in the mission home despite being across the street from a government health center. Well aware of the legal risks, the community mobilized in support of the mission home birth attendant even after she was arrested. Who is responsible for the second death in this remote village in Igi? The community reopened the mission home, despite state sanctions, and asked Kehinde to stay. Is this a case of malpractice? Neglect? Or as the state sees it, murder?

Meanwhile, the state's attempts to care might be seen as overly authoritarian. On what grounds, can the state decide where and how women will be allowed to deliver. The state has not bothered to look into Igi's problems re-attaining electricity, but they are quick to arrest a woman who is serving a community that has chosen her. Are these earnest attempts to keep women from dying during childbirth, or an effort to demonstrate modernity to a global community that responds only to indicators like "place of delivery"? While the state claims that mission homes are "death traps," there is no comprehensive data on how many deaths occur in them. I chose to highlight a maternal death in Igi in order to illustrate the state's interventionist policies, but deaths also occur in state hospitals even with all their advanced biomedical trappings.

To return to the question asked in Chapter Two, now stated differently, how is it that a

country as deeply religious as Nigeria has developed such a sustained campaign to ban church births? It appears that Ondo's forensic profile depends on it. And Ondo is not alone in its efforts. The governor's wife in Cross River State initiated a campaign against "church births." She travels across her state urging women to let go of their beliefs in the power of prayer alone to ensure a safe delivery. In order to align itself with international goals (and therefore continue to be eligible for international funding), Nigeria must at least appear "forward thinking." This requires leaving anything otherworldly in other worlds. As Pentecostalism continues to grow alongside growing concerns about maternal mortality, it is crucial to note the forms of religiosity deemed permissible in "modern," "secular," Nigeria. For instance, it is perfectly acceptable to believe in God, but to believe in the miracle of divine healing is less so. Pentecostalists, known for their ecstatic forms of worship, speaking in tongues and trance-like states, do not fit the paradigmatic image of progress.

Yet despite local campaigns against mission homes and state laws criminalizing deliveries within them, the Nigerian state is quite obviously not actually aspiring to make religion disappear entirely. Instead, it seems to be working toward a transformation of religious practice in order to exist comfortably in what it sees as the modern world. I see what is happening here as a process of the state disciplining its citizens and producing idealized modern secular subjects. The secular operations of the state intervene on the religious in ways that define what are appropriate forms of religion. The challenge the Nigerian state is really grappling with is not that people are too religious as it sometimes claims. It is that people are becoming religious in the wrong way. To be atheist might be one acceptable answer as Igwe suggests, but to be a liberal Christian might be another one. This is an important distinction to make because it suggests that secularism, even that which the Nigerian state proposes, is not

absent of religion and atheism is not necessarily the worldview most compatible with development. Ondo public health programming is sustained by its Christian practices, just as many have shown how biomedicine is indebted in many ways to Christianity. Secular motherhood, then, is not neutral. Nigeria, operating as a secular liberal state, is not indifferent to religion, but rather seeks to reform religious practice and remake religious subjectivities. What makes Ondo's Safe Motherhood program a Secular Motherhood program is the way it seeks to regulate how religion is practiced and expressed in public life. These are not merely attempts to reduce maternal mortality but to produce the kind of religious subject that is compatible with the secular liberal state.

However, my work also suggests that because the care received in mission homes is not merely a response to precariousness, the government's disciplining techniques—improving access to hospitals and outlawing births in other settings—are not effective. The care provided in mission homes do not fill a lack. It is instead an act of faith that communities feel the need to protect. Associations between faith and healing have a long history in Nigeria that cannot be so easily discursively unlinked. Reproductive practices, because of their centrality to national concerns about population, development, productivity, and even morality, are configured as elements of public life that should be made secular. Yet, even as their bodies and their wombs are subjected to secularizing measures, women respond with practices they use to reinvigorate their faith and enact their own vision for what progress might look like.

Conclusion
The Narrow Path: Stakes for salvation

"My goal is to explore the ways in which understanding the institution of motherhood and its unique position in Yorùbá society can aid in the struggle to transform the lives of all Africans, but especially the lives of African women and children."
– Oyeronke Oyewumi, *What Gender is Motherhood?* (2016)

To Be Delivered is in many ways a response to decades of unsuccessful attempts to substantially improve maternal health and increase the likelihood of surviving pregnancy in Nigeria. I aimed to offer a new perspective on the problem by centering the experiences of black women in an arena that has paradoxically left us out. In so doing, it became necessary to challenge not only global health characterizations of maternal mortality but the very politics of knowledge that these characterizations rely on. This hierarchy of understanding operates through a series of fixed binaries—modern/tradition, secular/religious, rational/irrational, science/magic—that are well studied in anthropology and other critical fields and yet still so often taken for granted. Taken together, these overdetermined dichotomies have the effect of creating a prescriptive vision of what should be. They support what Michel-Rolph Trouillot (2002) outlined as "North Atlantic universals"—modernity, development, progress, democracy; and to these, I add secularism. As normative projections, they drive sensibilities, persuasions, cultural assumptions, and ideological choices while their precise geographic and historical localizations remain hidden.

This project of modernity inspires and relies on a vision of progress which maps time and space along a narrow path. My intention was not to redefine what counts as modern, nor was it to demonstrate how the lines blur to allow the modern and traditional to blend (Piot 1999; Keane 2006). I was, instead, interested in clarifying how and to what effect modernity as a universal, both as a means and an end, is a "history of power as told by power itself" (Foucault 2003, 133) or placed in the context of global health, how development practices produce discourses about

African women that justify their own existence more than they represent the experiences of the women themselves. I argued that attending to this problem of representation has spiritual, economic, political, and, of course, health implications for women.

While the disregarded stories of African motherhood are diverse, I focused on the question of religion and secularity because the act of labeling a practice religious has come to have the effect of delegitimizing it. Thus, of the experiences of pregnancy in Nigeria, those that are considered to be religious are most incoherent to global health communities and least likely to be included in the dominant discourse unless otherwise ascribed to more legible political economic concerns. If as I and other secular scholar argue, the secular entails the very act of discerning between the religious and the nonreligious, biomedicine has played an integral role in constructing political secularity. The links between biomedicine and the modern project having been thoroughly explored, I elaborated the role of secularity in biomedicine and political secularism in the modern project. The exclusion of certain practices and forms of knowledge is authorized by biomedicine's claim to secularity even as it is informed by particular religious affects and sensibilities that can be traced to the geographic and historical religious origins of present-day notions of secularity (Asad 2003; Taylor 2007). In this way, the secular has become an important dimension of what we call modernity and its defining forms of knowledge and practice.

In order to interrogate these ideas, I asked, how is a secular body made? I posited that paying attention to disciplining acts of a secularizing government, might help us to reveal the contours of a "secular body" (Hirschkind 2011). This meant illuminating the discursive and structural processes by which Ondo sought to portray itself as a forward-thinking, progressive modern state. What became clear was that in Nigeria, it was no more difficult to achieve a clear

picture of a secular body than to describe a religious one. This is to say, the religious body that we think we can identify from a secular perspective (a universal essential transcultural and transhistorical category) is actually just as elusive as the secular body; it too is likely lost in the humdrum of the everyday, what J.D.Y Peel called in his description of precolonial Yorùbá culture, "making country fashion" (Peel 2003, 88–122). The mutability of these concepts, the religious and the secular, is important to pay attention to because when we understand them as fixed, we miss how they can be manipulated for specific ends.

In Nigeria, delivery in mission homes was deemed to be too religious to be compatible with an image of modern Ondo and birth attendance in churches was criminalized. I emphasized that the problem for the Ondo government was not that women were religious at all, but in how they were religious. In other studies of political secularism, scholars point out how rational subjects are presumed to form a public only through relegating beliefs to the private sphere, obscuring a latent Christian genealogy which makes for a polity more hostile toward certain religions. Saba Mahmood (2015) argued that this project is haunted by structural contradictions. It entails the simultaneous regulation of religious life and the construction of a religion as a space free from state intervention. These attempts at depoliticizing religion actually have the effect of embedding it within the social life of the polity in Egypt. Ondo's government, however, makes no claim to secularity as the state does not purport to be devoid of religious practice. Every state meeting is opened with a prayer given by pastor and closes with a prayer given by an imam. Yet, the limits of acceptable religious practice are determined by universalizing principles of secularism, concepts and institutions introduced through colonial rule and thus entwined in a history of enduring power inequalities.

In this way, Ondo state lays bare the latent religiosity that political secularism elsewhere obscures. Religion is expected to be practiced in public, but only in a restricted set of ways. Within *Abiye*, women were encouraged to sing praise and worship songs in government hospitals but were forbidden from delivering in churches. They might bring sanctified water or anointing oil with them to the hospital but would be chastised for using these materials in place of vaccines or antimalarial pills. While these paradoxes were informed by North-Atlantic liberal norms, they took shape in ways specific to Nigeria. Ondo's access to resources depended on its ability to perform secularism as funding agencies like the World Bank expected Ondo to demonstrate its adherence to policies grounded in theories of secularization. The expectation was that religious belief would eventually be replaced by scientific rationality, that women would stop attending mission homes once they were exposed to the benefits of biomedical care offered in government hospitals.

This did not prove to be true. Pregnant women continued to deliver in mission homes even after hospitals were built across the street from them, even after the services were made effectively free in these hospitals, and most surprisingly (to the state), even after the act of delivering in a church was made illegal. Moreover, having faith yet collecting care at multiple sites including missions homes, biomedical health centers, and with traditional healers was not experienced as contradictory for the pregnant women I followed. I used language and historical practices to argue that Yorùbá cosmologies differ from the secular Protestant view of a world in which the belief is an inward experience and the material and the spiritual worlds are distinct. For pregnant Yorùbá women, belief was demonstrated through acts of faith. So as the Ondo continued to attempt to draw lines between church and state in order align with international models of health care, these women had no trouble crossing them. Even the state itself appeared

ambivalent, wavering between strict adherence to foreign standards of acceptable biomedical care and a reverence for the local relevance of other genres of intervention. When the mission home attendant of Igi returned to her village to continue attending deliveries following her release from jail, she was not further pursued by Ondo state officials. If Ondo state is at times ambivalent over the question of religion's role in the modern space, global health communities are decidedly not. It is this failure to see this important dimension of women's lives that limits the ways the problem of maternal mortality is described and addressed.

Motherhood in Nigeria is especially imbued with spiritual significance. To exclude this aspect from our understandings of maternal health is also to obscure fundamental aspects of the experience of childbirth and motherhood. While global health has a strong trajectory of including religious beliefs as "culture" to be factored into producing effective interventions, I argued for a more radical engagement with religious practices that does not dismiss them as incorrect but strongly held ideas among a target population. Rather, I ask what might we learn by allowing women's demonstrations of faith to stand on their own. My engagement with African literature and African feminisms responds to this area of neglect. These texts offer theory, in part by attending generously to religious affects, for how we might come to know processes surrounding childbirth and the meaning of motherhood.

Attention to the discursive history of "Safe Motherhood" reveals a campaign supported by a singular conception of African women. Maternal death narratives, reductive stories of women dying in childbirth described in Chapter Three, were popularized in the 1980s around the time that new figures quantifying the magnitude of the problem of maternal mortality were made available. These representations of suffering African women were widely circulated and in turn continue to shape health care programing in places like Ondo. The form that *Abiye* took directly

correlated with the "Three Phases of Delay" model, a secular product of the maternal death narrative. However, it quickly became clear that though *Abiye* was effective in increasing access to biomedical service, this didn't correlate with a significant increase in the numbers of women choosing to deliver in these spaces. *Abiye*'s narrow vision for progress had not attended to the Pentecostal concerns of most of its targets.

African literature gives us a different analytical lens through which we can study the problem of maternal mortality. I employed the tools supplied by black feminist/womanist thought – both African (Chikwenye Okonjo Ogunyemi) and African-American (Alice Walker) – to examine how anxieties surrounding expectations of motherhood for womanhood structure how and when women access care. Following Chimamanda Adichie and Chinua Achebe, I called for "a balance of stories" and explored the implications this diversity might have on public health interventions. I focused on narratives of pregnancy and delivery, the paths that women take to the stream in order to return with pots of water. My goal was to flesh out the less often articulated aspects of the full spectrum of maternal experience in an attempt to counter potential danger of maternal death narratives. Unlike maternal death narratives in global health, which tell a singular tale of lack, the literature of Buchi Emecheta, Flora Nwapa, and most recently Ayobami Adebayo tell fuller stories of motherhood, of social pressure, of desire, of loss and joy. The women in these stories are not merely represented as victims of patriarchal societies. Instead, *public motherhood* is potentially powerful. Despite assumptions that Africa has nothing to teach the world about women's empowerment, following Oyeronke Oyewumi, I argued that Yorùbá conceptions of motherhood honor the spiritual and material elements of the procreative role and connect motherhood to leadership and societal wellbeing.

What should be clear is that this move is not meant to romanticize experiences of motherhood in Nigeria. Similarly, my turn from maternal death to maternal survival is not meant to downplay the very real life and death stakes of giving birth in Nigeria. Instead my arguments support two central claims: First, that racial legacies of colonialism as enacted through the intimately related institutions of global capitalism, political secularity, and global health must be addressed in order to tell more complete stories about women and their health, and second, that literary texts are an important source of this theoretical innovation as the novels I have chosen attend to historical formations of violence without being overly determined by them.

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In her critique of Charles Taylor's A Secular Age (2007), Saba Mahmood (2010) asks "How might the story of Christian secularism be told otherwise?" (292) The "other" of otherwise carries both the notion of reformulation/rethinking and that of the "other" to "Western normativity." She calls for us to parochialize "Western European" conceptions of secularism by making the work of secular power visible especially as its practices are globalized. Following Mahmood, I ask, can development be otherwise? How do development goals in the form of global health indicators (e.g. decrease maternal mortality by half or achieve 75% deliveries in a skilled health facility) constrict visions of progress? Much anthropological work has attempted to render development's normativity visible and analyze progress as a problematic formulation, but here I am interested in the promises of salvation as model for development/progress. What does it looks like when Nigerian Pentecostals attempt to replace teleology with eschatology?

Within the array of myths that make up Yorùbá cosmology, there is the notion of "*Ayé l'ojà, Òrun n'ilé*." It can be translated as, "the physical realm is a market, the spiritual realm is the home," but the phrase requires more unpacking than a direct translation. In Yorùbá

cosmology, *òrun* is not quite a heaven in the sense of another world that serves as a destination at the end of material life. It is more of a spiritual presence that is all around us but beyond our capacity to apprehend. *Ayé* alternatively represents those aspects of the world that we can readily appreciate. But importantly, both *ayé* and *òrun* are halves of the same whole that is the world we live in. Each individual starts as their *orí,* a spiritual spark or consciousness in *òrun*. The *orí* picks a destiny or fate, a journey to walk on at which point *Olódùmarè* (roughly equivalent to the divine creator) gives them *emi*, the breath of life. The individual then travels from *òrun* past the seven seas of forgetfulness to reach *ayé*. It is said that during this journey, the individual loses their ability to know *òrun*. They forget. Acts that are now considered to be religious—studying *Ifá* divination verses, consulting a priest, making a sacrifice to an ancestral spirit—are all attempts to remember, to regain consciousness of *òrun*, to be *born again*.

Chapter Two engaged Nigeria's long history of missionization and medicalization in relation to parallel developments of Pentecostalism and its practices of faith healing, especially in addressing the reproductive desires of women. Christianity overwhelmed the forms of life it encountered in Nigeria, displacing or transforming Yorùbá practices, but in the process, it was itself transformed. Nigerian Pentecostalism and especially its earliest forms (the Aladura movement) are important legacies of this dialectic process (previously described by the Comaroffs in relation to South African Zionism).

> Enter through the narrow gate. For wide is the gate and broad is the road that leads to destruction, and many enter through it. But small is the gate and narrow the road that leads to life, and only a few find it (Matt. 7:13–14 KJV).

Jesus concludes his Sermon on the Mount by warning his listeners that the path to salvation will not be easy. In Christian theology, eschatology provides a vision of a future world in which

reconciliation with God is achieved for humanity. Implied in this vision is a dialectic between sin and salvation, which Nigerian Pentecostals take especially seriously. We see this in the way that one of the contentions African Independent Churches had with the Protestant churches they broke from was the timing of baptism. Christ Apostolic Church doctrines underscored the importance of adult baptism. The significance of being "born again" was reinvigorated with the transformations in Pentecostal practices that took place in the 1970s. Neo-Pentecostalism is in many ways centered on narratives of cycles of breaking and healing relationships with God, other's, and one's self. Sin, and its recognition, is paramount to this dialectical progression.

At a Redeemed Christian Church of God Sunday service I attended in Akure, the pastor asked, "Is anything too hard or too wonderful for the Lord?" before specifically calling for a six-year old and a three-year old child to be brought in front of him. "Quickly, quickly," he spoke urgently. Seconds passed. A three-year-old girl waddled on to the stage holding the hand of a male usher. Soon after a six-year-old boy beamed brightly as he strode on stage, and the usher remained standing behind the girl. The two were made to stand opposite each other. The pastor explained, "We are all this small child [pointing to the little girl] and even though evil may face us, it cannot over take us because we have the will of God behind us [referring to the usher]." He pointed accusingly at the six-year-old boy, "This one here is the devil." The boy beamed brightly, chest puffed out as he walked away from the front of the room after the demonstration was over.

Coda

It seems fitting to conclude with the end of the story of *Abiye.* In the time since I finished my fieldwork, a state election was held and a new governor from the opposing political party, All Progressives Congress, was elected. Governor Rotimi Akerelodu assumed office in early 2017

and appointed a new set of commissioners including a new commissioner for health, Dr. Wahab Adegbenro, over the course of the next several months. Under this administration, the *Abiye* and *Agbebiye* programs have been forsaken and effectively ceased functioning. Thus, an end to an almost decade-long endeavor imitated by former Governor Mimiko.

The transition of government was particularly fraught for the health sector as Akerolodu's government inherited several months of unpaid salaries owed to physicians working for Ondo's Primary Health Care Development Board. When Akerolodu suggested that these physicians forgive the government this outstanding debt, they threatened to strike. This would not be the first time strike was suggested, and in fact, at the end of the previous administration's tenure, Ondo physicians had effected a strike over the non-payment of five months' salary. Though these salaries were finally paid, *Abiye* program was never revived. Not only have many Nigerian state governments suffered from budget constraints due to an economic crisis triggered by the sharp drop in the international price of crude oil in 2014 and 2015, but more recently, the World Bank project that supported *Abiye* was suspended due to allegations of fraud. It was thought that data generated to comply with the World Bank's results-based financing scheme were inflated for monetary gains. The reported achievements of *Abiye* (numbers of deliveries in government-sponsored facilities, for example) were too good to be considered true. Whether or not the numbers were false

As one might expect, *Abiye*'s demise is felt most directly by the Ondo's pregnant women. In the April of 2018, the price of a normal delivery, formerly free, was increased to N25,000 and women were charged N50,000 for Cesarean sections. Soon after the new prices were announced, pregnant women staged a protest at the Ondo State Specialist Hospital in Akure. Over one hundred pregnant women blocked the main entrance of the hospital for several hours as they

shouted their frustrations with the new government. This continued until the commissioner for health, Dr. Adegbenro, appeared in order to let them know a mistake had been made and that they would not be charged for deliveries. Whether there had been a mix up or the government, intimidated by a group of incensed pregnant women, had made an about-turn is left for speculation. What we can take from this final scene against the backdrop of the previous chapters is that we will always miss something of the concerns of Nigerian women if their stories are filtered solely through secular liberal ways of knowing. That Ondo women want both the freedom to enact their faith by delivering their babies in mission homes and the option to receive free biomedical care in hospitals should come as no surprise if the diverse stories of African women are heard and familiar notions of the secular and the religious are decentered.

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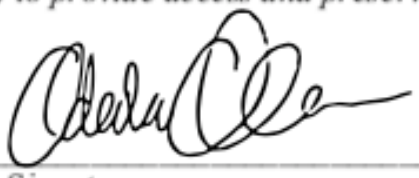

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