Recovery Adjourned: Curative Belonging between Cameroon and Germany

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The point of departure of my fieldwork and the cornerstone of my future Master's thesis is an event of a personal crisis. Shortly after the completely unexpected death of a close friend of my partner and me, we both tried to dive into the long-planned field research for our Master's programs[1] in Cameroon in October 2017. I intended to work with cancer patients to find out which treatment options they use and which coping strategies they develop to deal with their potentially life-threatening sickness. During a previous stay in Buea in 2016, I had noticed that in Cameroon there was no public health insurance system covering the costs for such treatment. At that very moment, however, I experienced a severe disruption of life myself, something that I will call *ontological lesion*[2] in the course of my prospective work. While I had planned to stay in the capital of the Anglophone *Southwest Region*, Buea, for about four and a half months, things turned out differently for me. Instead of doing research with people being affected by cancer, I became a patient myself. Instead of living there for several months, I had to return home after about four weeks.

Many anthropologists suffer from sickness in the field, yet, few of us turn this lived experience into our object of academic inquiry (cf. Runestad 2016) and thereby declare ourselves as our primary research subjects. The severity of my sickness, however, which caused me to be an in-patient in a local private clinic in Buea for almost two weeks and ended in medical repatriation, induced me to do so. Sickness as such is nothing to be considered unusual but what characterized my own illness experience was the frightening incapability of recovery while in Cameroon. Back home in a German hospital in Berlin, on the contrary, the most critical symptoms of my sickness disappeared within a very short time.

The entrance area of the local clinic in Buea I was admitted to and did research on. Patients presented their primary complaints here and underwent first checks (weight, temperature, blood pressure). 2018 Copyright: Henriette Vogel

Coming from a white, Western, middle-class background, neither financial concerns, i.e., accessibility, nor issues of availability of (bio-)medical treatment in this Central African urban environment complicated my health situation in the field. While several diagnoses of gastrointestinal infections and their consecutive treatment with antibiotics should have provided me with everything needed for recovery, they did not.

Furthermore, while doctors, nurses and other caretakers gave their best to help me, they ultimately could not. What seems to have helped instead was going home. This fact leads me to an approach that considers the role of *belonging* as a crucial factor for successful healing in times of crisis, in times of disrupted trust in life and its (un)controllability, in times of *ontological insecurity* (Laing 1960; Giddens 1984, 1990).

One of the nurses standing in the clinic's pharmacy. According to the staff, the availability of drugs was not an issue. Patients instead struggled to pay the costs for the necessary treatment. 2018 Copyright: Henriette Vogel

Curative belonging, as I will argue, manifests itself through different aspects, some of which are sensorial habituation, expectations of local forms of care and treatment, and shared aetiologies. It affects the entirety of a person's *bodymind* and is culturally dependent and acquired. Based on the assumption that human beings have pre-reflexive and affective attachments to places, languages or material objects, which account for their sense of *belonging* (Slaby/von Scheve 2019: 21), *curative belonging* refers to an "affective social positioning" (Röttger-Rössler 2016: 4), a "felt bond" (ibid.) with certain settings of recovery and the practices that are being performed there. As it is not only people but also non-human actors that participate in the healing process, this text puts a certain focus on *actors of care* (Radziwinowiczówna et al. 2018) as well as *eco-pathologies* (AGMA 2019) that might differ across various cultural contexts. Also, the impact that stereotypical "Western" ideas about medical professionality in sub-Saharan Africa have on recovery will be examined. The overarching question of this blog piece, therefore, is: which factors might have possibly hindered my successful recovery in Cameroon and how did they interact?

Autoethnography and online research

Because it is my severe sickness that constitutes the main object of my study (and the blog piece), I will analyze and represent the generated data from an autoethnographic point of view. Doing autoethnography means to expose one's vulnerability to a certain extent (Winkler 2017). It implies predominantly speaking *about* and *for* oneself rather than being represented by others. Nevertheless, it is not only my voice that I captured during this unexpected "field research." Phenomenological accounts of my lifeworld as a researching patient, my aetiologies and my interpretations of sickness (Kleinman 1988) were the main focus of this research, but they were complemented with some of the doctors' and nurses' conceptions about health and sickness, especially about my case. For the purpose of this blog piece, however, I will focus on the autoethnographic point of view.

Basically, my fieldwork was divided into two clear-cut phases. While I was physically present in Buea from the end of October 2017 until the end of November 2017 (phase 1), I did online research with some of the clinic's staff members by the means of WhatsApp chats, calls/interviews and collecting photos from the end of January 2018 until the end of February 2018 (phase 2) in order to find out about their daily duties, about difficulties they encountered while doing their jobs and about their general perceptions about what it means to be healthy or sick and what it needs to recover. My digital research was followed by another one week of physical presence in Cameroon in late February/beginning of March 2018, including visits at the private clinic I once was admitted to and later did research on. Phase 1 captured my own sickness experience in the field from a subjective, phenomenological perspective (autoethnography), while phase 2 tried to frame the local context of my sickness experience through systematic inquiry (online ethnography).

Sickness in the field and (trans)local caretakers

During my four-week stay in Buea, I was diagnosed with different infectious diseases by means of lab tests – all of them were performed in the same clinic, which was recommended by our close (Cameroonian) friend and research assistant. His aunt, suffering from a brain tumor, also went there for palliative care.

The first diagnosis I received was typhoid. Having suffered from gastrointestinal symptoms, including constant nausea and occasional vomiting right since I arrived in Cameroon, I took the lab results with great relief. Before we went to Cameroon, my partner and I had been on a brief vacation in Egypt, where my symptoms already had begun shortly before the departure to Central Africa. Back then, however, I interpreted them as some reaction to the upcoming stressful time in the field. But when the symptoms persisted for more than a week after our arrival in Cameroon, I started to worry. The abdominal pains I experienced were more severe than any other stomach aches I ever had before. Still, I was reluctant to reach out for (bio-)medical consultation. Probably they would not find anything anyways, I thought. But eventually, I gave in to our friend's plea to get myself examined by a physician. My partner and I accepted his offer to drive us to the clinic at the outskirts of Buea.

My doctor was an experienced professional who, at first, appeared rather intimidating and authoritative to me but then turned out to be extremely caring and trustworthy. I knew that I could rely on him. When the lab results came back, I was surprised about the findings but, ironically, I felt happy. The symptoms I was showing obviously were connected to a common infectious disease and not only signs of stress. The prospect of curability with the help of simple antibiotics took a lot of pressure away from me. I would take the medication for ten days as prescribed, rest in the apartment and be able to contact my first research participants then. “Everything will be fine,” I said to myself.

Shortly before the tablets were finished, the backlash came. I felt worse than before, and my hopes for a near recovery were shattered. Our friend took me to the doctor again. This time my partner was out of town, and I had to rely on other caretakers. The most important one was our mutual friend who was physically around, but equally important were two, three friends of mine back home, standing by me via WhatsApp messages. The doctor asked for a new lab test. The typhoid was gone but what the lab technician found instead was amoebiasis. Due to severe vomiting, my doctor proposed that I could stay in the clinic for one night and receive the antibiotics through an IV. I happily accepted.

Finally, I was allowed just to be sick for some time. There would be other persons taking care of me and my condition. I could escape the loneliness of our apartment (my partner was out at court or in the office most of the day to do his research). I could escape the constant noise from the city center where we lived. I could profit from the cool in the clinic which was located somewhat uphill, and I could rely on constant electricity and water supply which was not guaranteed at our place. I could lie in my patient bed with the IV attached and text friends in Germany via WhatsApp to tell them about my misery and find some relief in their consolation. They understood that all the pain from the sudden loss of our friend was dragging me down, that being in the field was tough. That I felt isolated and desperate because of my fragile health. That it hurt not to be taken seriously as a female researcher but to merely be considered as the researcher’s “wife.” They tried to cheer me up and were a significant source of at least a little ease.

A view into PRIVATE WARD 2, my patient room with a small bathroom attached. Most of the time in the clinic I spent there, receiving IVs containing antibiotics, saline solution, or glucose syrup. 2017 Copyright: Thomas Götzelmann.

As my response to the IVs turned out negative in the course of the first night at the clinic, I eventually did not stay as an in-patient for one but for ten days. My partner came back from his work trip in the evening of my admission and stayed with me at the clinic for most of the time in the next one and a half weeks – at first during visiting times only, which ended at 7 or 8 pm. After a few days, when we asked if he could use the other bed in my room that was still free, the nurses laughed. Of course, he could sleep there. It was the bed designated for the caretaker anyways.

Having checked on various reasons for my failing recovery ranging from side effects of the malaria prophylaxis over worms, hepatitis A and diabetes to a pregnancy, we all ran out of explanatory models over time. Why did the antibiotics not show the intended effect? Why did I continue to vomit? Was there something we had missed apart from the typhoid and amoebiasis diagnosis? One day, our friend's family came to visit me and suggested to transfer me to another clinic. I refused. I was desperate. I was scared. And I was not ready to give my recovery another try. The doctor ordered more fluids to get me stronger. I had not eaten anything for more than a week; all my body accepted was bottled water. The backs of my hands and my arms were rejecting the cannulas that were supposed to get the liquid help into my system. At

one point, one nurse tried to insert a cannula into my foot, but that did not work either. One of my “transnational caretakers” back home suggested asking my health insurance for medical repatriation. I disapproved. Then I thought about it again. He was right. I had to go home.

To be honest, that was the only thing I wanted after having stayed at the clinic for several days without improvement. But at the same time, I considered it a concession of my failure as a researcher which was painful and made me feel embarrassed. All the effort, time, and money I had put into this project would have been wasted. And what would happen to my Master’s thesis? I e-mailed my professor. She told me not to worry, to come home and recover first. But letting go was not easy, and I also felt sorry for everything the clinic staff did to help me, yet to no avail. Another disappointment. Bad researcher, lousy patient.

Medical repatriation and definitions of “sickness”

When my health insurance sent me an e-mail confirming that a chartered, tiny plane would come to get me and bring me to Berlin, I felt overwhelmed. I was talking to my mum on the phone and cried. “Aren’t you relieved?” she asked. “I feel so, so ashamed. Do you know how much it costs that they are coming here, just for me? I came here to work with cancer patients, and now my insurance puts immense amounts of money in making sure I will be okay. That’s so unfair.” The friend at home who suggested contacting the health insurance for medical repatriation at first consoled me that this was just the way the concept of insurances worked. Many people pay money into it, and in the end, only very few of those contributors will need medical assistance. He had a point there. But still.

I knew that I would never tell anybody about the incident of repatriation, if not absolutely unavoidable.

When the ambulance came on 24th November to get me to the airport, where the German crew and a German doctor, as well as a German paramedic, would wait for me, I was scared about how I should manage the 2-hour drive to Douala on a road that was not always very flat. To my surprise, I already felt better when I entered the ambulance and lying there while driving was not a big problem. Before I left, many members of the staff gathered at the main entrance to see me off. Some of them took pictures. My boyfriend cried (something which impressed several nurses, as they would later tell me). Somehow, my sickness became a social event.

View from the inside of the ambulance on the tarmac in Douala. Against my expectations, my health situation improved already while driving in direction to the airport. Getting closer to home seemed to have a positive influence on my well-being. 2017 Copyright: Henriette Vogel.

The actual flight with the tiny plane was less unsettling than one would expect it to be. It was equipped with the very basics, a small daybed that I could lie on more or less comfortably, a toilet “for emergencies,” a monitor to observe the patient’s heartbeat, different syringes and liquids and so on. The take-offs and landings were very smooth. The crew was extremely professional and relaxed, to them, this trip was nothing but routine. They travelled around the world to pick up patients and brought them to their home countries in case they fell sick abroad. They also picked up wounded UN-soldiers from war zones. When they told me that I was not sick, I did not feel offended. I imagined how minor my health condition was compared to many other cases. Later on, I would remember this comment about my “lack of sickness” and interpret it differently.

After a short stop at a military base in the Algerian desert, we arrived in Berlin in the early morning of 25th November. An ambulance came to pick me up from the airport and to bring me to a hospital. The paramedics were talking about the fact that the van might have to be foamed with a special disinfectant after my admission at the hospital due to the unknown nature of my sickness. At least, we all agreed that this seemed far over the top. But possibly they had to do this cleaning procedure anyways because of German public health measures, one reason why I

was also not allowed to take a regularly scheduled flight from Douala to Berlin.

Arriving at the hospital, I got admitted to the department of infectious diseases where I was put in an isolation room. Everybody who wanted to enter had to pass the so-called *airlock*, an extra room separating the corridor from my patient room. There one would put on a special gown, a face mask, and gloves which one would wear to visit or examine me. When staff or family members came by, all I could see was their eyes. The whole equipment had to be thrown away immediately when they left again and went into a special dustbin in the *airlock*. Equally, I had to dress up like that when I wanted to leave my room and take a short walk in the corridor, which was very strenuous as I had lost about 5 kilos of weight in a very short time and felt quite weak. But I did not feel comfortable to step out of my room anyways.

View into my isolation room at the department of infectious diseases at a hospital in Berlin. 2017
Copyright: Henriette Vogel

What happened at the hospital then is what later on would astonish some people and reaffirm others in their explanatory models concerning my failed healing: I recovered very quickly.

All the pharmaceutical treatment I received from German medical staff was one Ringer's solution at the airport in Douala to hydrate me during the flight and some antiacids at the hospital in Berlin to bind the superfluous gastric acid in my stomach. Apart from that, no additional infusions or tablets were given to me. They were simply not necessary because, on the one hand, all the results from the extensive lab tests were negative. No diagnosis could be made. On the other hand, my main symptoms, which were labelled as gastroenteritis, had mostly disappeared and slowly but surely I could finally eat again. I partly could rely on my usual bodily functions again. What I was still struggling with was dizziness, difficulty to walk, and an intense sense of the blood being pumped through my legs but none of this mattered to the doctors. One of the senior physicians even asked how I possibly came up with the idea to ask for medical repatriation. Sadly, I felt too overwhelmed and offended by this question to give a firm answer. I just mumbled something about that it had been my health insurance's decision… From that moment on, I interpreted the paramedic's previous comment from the flight that I was not even sick differently. Obviously, the German medical personnel and I had very different ideas about what sickness was or had to look like.

After the short stay of three days at the hospital, I was officially declared healthy and regarded as ready to go home. I did not feel that healthy yet but I had no choice, so I called my parents to pick me up. I could not have carried my 20kg backpack in public transport. Sometime before my release, a doctor came to have the dismissal interview with me. What he then said, equally startled and paralyzed me: the only thing they eventually did find in the lab was that I was infected with a multiresistant hospital germ.

He said it was not a big deal, it would disappear by itself after some time because I was young. I should only avoid direct contact with pregnant or elderly people and babies or persons undergoing immunosuppressive therapy. I would get follow-ups at my general practitioner's office and that, of course, I could go out and use public transport or meet friends – as long as they were not pregnant or had an impaired immune system. I wondered how I should avoid all those people while moving through Berlin or my hometown. But as fast as the doctor had broken the news to me, he quickly disappeared again. I was left with a lot of insecurity about the impact my infection would have on my everyday life. Not to speak about the uncertainty if I could possibly do another research in the medical field in the following couple of months while I was carrying tiny somethings inside me that could seriously harm physically weakened persons I originally intended to work with. But these were questions to ask that nobody would answer.

Conclusion: Failing fieldwork? Some thoughts on the value of thwarted plans

The sickness experience I made during fieldwork was extremely challenging, and for quite some time, I questioned my work as an aspiring medical anthropologist or my general suitability for this discipline. The idea of "having failed" in the field was painful, and the loss of control was frightening. I had been prepared to encounter certain problems in the field, first of all, because of the tense political situation in the Anglophone regions of Cameroon (cf. Pommerolle/Heungoup 2017). After Anglophone protests against marginalization had been struck down violently by the state at the end of 2016, a separatist state called *Ambazonia* was

declared in October 2017 (cf. Okereke 2018). During the course of my stay, curfews, arbitrary detentions and unpredictable violence including deaths then took place in the two Anglophone regions. I also had been concerned about the feasibility of my research approach. Would patients open up to me? How would I be able to talk to them without any Pidgin English expertise? Would they let me be around when they contacted a doctor or traditional herbalist, for example? How would I deal with requests for financial support? How would I deal with death?

I had been thinking about different content-related and methodological or ethical difficulties, yet, what I had not been prepared for was to experience the great vulnerability of *my bodymind*. What I somewhat had refused to do was to properly pay attention to me and my current life situation. Time surely was a factor, as we learned about our friend's death just about two weeks before our departure to the field. Back then, the thought of postponing the field research did not really come up. We just kept on going, just did what the schedule told us to do. We decided that life had to go on. Retrospectively, I am surprised about some decisions we or I made at that time. How could I ignore this *ontological lesion* and go to the field?

Mattes and Dinkelaker (2019: 227) state that "[i]t is reasonable to assume that any anthropologist working in the field, and not just the novices among them, will at one point or another face failure." Failure then is something intrinsic to fieldwork, nothing to be ashamed of and not a sign of incapability. Research plans can be thwarted for a variety of reasons, not necessarily as personal as in my case (cf. Mattes/Dinkelaker 2019). Writing about our failures in fieldwork has its pitfalls and renders us vulnerable. Equally, it offers insights that profit from the researcher's involvement. It shows how our personal life situation shapes our research, or rather, how our research and our life are inseparable to a certain extent.

My persistent sickness in the field radically forced me to change my research question. Suddenly, I became a patient, and at a certain point, I decided to turn myself and my sickness experience into the main subject of my research. Based on my experience that a common infection could turn into a complex problem unresponsive to biomedical drugs, I realized how important *curative belonging* could be for successful healing. Because we are affectively bound to the sensual-material world we live in, it is of great importance *where* we get sick and *where* we try to recover (cf. Desjarlais 1992). My affective bond to the healing setting in Cameroon was not a curative one. There were many sensual impressions, ways of dealing with bodies, forms of care, explanations for my symptoms or treatment approaches that I was not used to, that at times surprised, overwhelmed, irritated or sometimes also scared me. Even though they were not the initial cause for my sickness, they inhibited my recovery because they affected me on a very essential level. In a moment of an *ontological lesion*, when things seemed to fall apart around me, returning home was the effective cure for me instead. Things, smells, tastes, sounds, and practices were mostly familiar there and comforted me with their predictability. What can make us sick then is not only pathogens in the biomedical sense or "mental stress," like the loss of a loved one, in a psychological sense. What can equally contribute to sickness is the relationship between our environment, non-human beings and us, i.e., the eco-pathology (cf. AGMA 2019), which can invade our *bodymind* like any other pathogen.

So far, there is just a small body of anthropological or sociological literature dealing with the

researcher’s sickness. While Paul Stoller (2004) talks about his lymphoma, Pamela Runestad (2016) writes about her stay at a Japanese hospital prenatally to the birth of her baby. Ann Neville-Jan (2003) describes her life with chronic pain, and Gerhard Nijhof (2018) reflects about the relevance of his intestinal cancer diagnosis. Three publications were already written in the 1980s and 1990s, one authored by Robert Francis Murphy (1987), the other one by Irving Zola (1982), both dealing with disability. The third one was written by Arthur Frank (1991) and deals with his heart attack and a cancer diagnosis.

What all of these publications have in common is that they deal with long-term or chronic illnesses or complications prior to childbirth. It is rare, however, to find detailed accounts about researcher’s acute illnesses in the field that go beyond a side note in their published monographs. With this blog piece and my future MA thesis, I hope to make a small contribution to closing this research/representation gap and allow other young anthropologists to get some impressions of fieldwork narratives that are all too often silenced.

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My research would have never been possible without the great openness the staff of the Mount Fako Clinic***[3]*** showed for my unusual endeavor. I am still amazed by all the time you dedicated to my work and the patience you showed for my inquiry. I wish for peace to come in the Anglophone Regions in Cameroon and for times in which the important jobs you do are more valued.

One constant throughout my field research was Divine. You were my compass, my teacher, and my source of ease. I am deeply grateful for your reliable help in shaky times.

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I dedicate this article to Christian.

Author

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[1] My partner, who does a MA program in Social and Cultural Anthropology at the MLU Halle-Wittenberg, equally went to Buea to do his field research but in the field of legal anthropology.

[2] The idea of an *ontological lesion* is a conceptual fusion derived from both Ronald David Laing's (1960) / Anthony Giddens' (1984,1990) concept of *ontological security* and Kaja Finkler's (2001) notion of *life lesions*. While Finkler applies her concept to long-term adversities in patients' lives that fuel chronic but non-life-threatening symptoms (Finkler 2001: 3), I use the term *ontological lesion* to describe a moment of acute adversity that equally contributes to sickness, yet, a rather critical but temporal one. O*ntological lesion* refers to an individual's state of being-in-the-world that was injured by a significant life event interrupting the integrity of that

person’s *bodymind* and resulting in clinical, non-chronicized symptoms.

[3] The real name of the clinic has been changed for this text.